Volume 68, Number 3 Summer 2017 $6.95

Sonoma Medicine

FEATURE ARTICLES
Single-Payer Health Care

INTERVIEW
SCMA President
Peter Sybert, MD

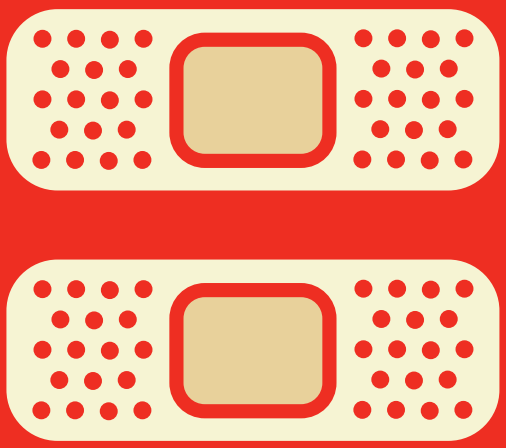
SONOMA COUNTY MEDICAL ASSOCIATION
S·C·M·A

Leading Sonoma County into better health

Equals make

THE BEST PARTNERS.

We're taking the mal out of malpractice insurance.
As a company founded and led by doctors, we know what keeps you up at night. It's why we partner with practices of all sizes to help manage the complexities of today's healthcare environment and reward the practice of good medicine. Because when you have a partner who's also a peer, you have malpractice insurance without the mal.
Join us at **thedoctors.com**



THE DOCTORS COMPANY
medical ~~mal~~practice insurance

Volume 68, Number 3 Summer 2017

Sonoma Medicine

The magazine of the Sonoma County Medical Association

FEATURE ARTICLES

Single-Payer Health Care

7 EDITORIAL
The Great Single-Payer Debate
"One possible solution to financial inequities is single payer, a Canadian-style universal health care system, commonly known as Medicare for All."
Anastasia Coutinho, MD, MHS

9 MEDICAL IDEALS
Envisioning Single Payer
"A single-payer financing system covers everyone from womb to tomb, with all necessary medical and dental care, for much less than our current model."
Parker Duncan, MD, MPH

13 POLITICAL ACTION
California Single Payer Pros & Cons
"The most serious threat from single payer is that the government could pay all care at Medi-Cal rates, which are typically one-third to one-fourth of Medicare rates."
Richard Powers, MD

15 CALIFORNIA MEDICAL ASSOCIATION
SB 562: Oppose Unless Amended
"The CMA shares the authors' goal of universal health care coverage for all Californians, but at this time SB 562 is counterproductive."
Juan Thomas

17 H-PEACE
Health Care Activism
"Our group formed shortly after last November's elections to defend health care rights and institutions from threats that may affect the health of our community."
Toni Ramirez, MD, Jenny Cecilia Fish, MD

DEPARTMENTS

5 LETTER FROM THE EXECUTIVE DIRECTOR
"We have been very busy here at SCMA during my brief tenure."
Wendy Young

19 INTERVIEW
SCMA President Peter Sybert, MD
"There are some very tough decisions to be made, both at the state and national level, and if you aren't participating as a stakeholder, the decisions will be made in your absence."
Wendy Young

Table of contents continues on page 2.

Page 34: Wine & Cheese Reception

Page 39: The Red Shoes

Cover photo by Will Bucquoy.

Sonoma Medicine

DEPARTMENTS (cont.)

22 COMMUNITY HEALTH
Open Clinical Trials in Sonoma County
"Beginning with this issue, *Sonoma Medicine* is listing open clinical trials in Sonoma County to increase awareness of local medical research and to benefit physicians who may wish to refer patients."

25 LOCAL FRONTIERS
Clinical Fasting
"Water-only fasting (complete abstinence from all foods and beverages except for pure water) is now used therapeutically to initiate physiological responses that may promote self-healing."
Toshia Myers, PhD, Alan Goldhamer, DC

29 MYSTERY CASE
Nocturnal Leg Cramps
"What additional observation suggests a non-pharmacologic strategy to relieve my nocturnal leg cramp symptoms?"
Kenneth Herrmann, MD

30 CURRENT BOOKS
The Torture of Uncertainty
"Though neurosurgery is a refined subspecialty of medicine, I think any physician . . . can identify with Marsh's self-reflections."
Kristen Yee, MD

32 OUTSIDE THE OFFICE
The Web's 10 Best: Take 1
"This is the first installment of a recurring feature where *Sonoma Medicine* shares 10-best lists of web content."
Brien A. Seeley, MD

39 MEDICAL ARTS
The Red Shoes
Matt Joseph, MD

40 THE LAST PAGE
Au Revoir
"After a quarter century of editing *Sonoma Medicine*, I have decided to retire. There's no reason other than the passage of time and the lure of a deadline-free existence."
Steve Osborn

34 SCMA Wine & Cheese Reception
36 SCMA Awards Gala
38 Physicians' Bulletin Board
38 Ad Index

Sonoma County Medical Association

Mission: To enhance the health of our patients and community; promote quality, ethical health care; and foster strong patient-physician relationships and the personal and professional well-being of physicians through leadership, partnership and advocacy.

Board of Directors

Peter Sybert, MD
President
Patricia May, MD
President-Elect
Brad Drexler, MD
Treasurer
Rajesh Ranadive, MD
Secretary
James Pyskaty, MD
Board Representative
Regina Sullivan, MD
Immediate Past President

Shawn Daly, MD
Steven Kmucha, MD
Marshall Kubota, MD
Kavita Mamtora, MD
Karen Milman, MD
Richard Powers, MD
Jan Sonander, MD
Robert Schulman, MD

Staff

Wendy Young
Executive Director
Rachel Pandolfi
Executive Assistant
Susan Gumucio
Advertising Representative
Linda McLaughlin
Graphic Designer

Membership

Active members 636
Retired 238

S · C · M · A
2312 Bethards Dr. #6
Santa Rosa, CA 95405
707-525-4375
Fax 707-525-4328
www.scma.org

Kristen Yee, MD

PLASTIC & RECONSTRUCTIVE SURGERY

707-525-8080

Member
AMERICAN SOCIETY OF
PLASTIC SURGEONS

Dr. Kristen Yee established her practice in Santa Rosa in 2014, providing modern and meticulous surgical reconstruction from head to toe for all ages.

—Certified by the **American Board of Plastic Surgery**
—Educated at **Johns Hopkins** University and trained at **UCLA** Medical Center, "The Best in the West."*

- Breast reductions and cancer reconstruction
- Skin cancer resection and reconstruction
- Congenital craniofacial reconstruction (clefts, craniosynostosis)
- Facial trauma, soft tissue reconstruction after trauma

Collaborates with:

- **Santa Rosa Memorial Trauma team**
- **UCSF Children's Hospital Oakland Craniofacial team**
- **St. Joseph Breast Tumor Board**
- **Sutter Melanoma Tumor Board**

Dr. Yee welcomes referrals from Sonoma County physicians, and she accepts most major health plans, including Medicare, Partnership, and Sutter Health Plus. She also provides a wide range of aesthetic surgical and non-surgical procedures. She can be reached at:

1111 Sonoma Avenue, Suite 112, Santa Rosa, CA 95405
Phone: **707.525.8080** Fax: 707.579.8820

For more information, visit www.Drkristenyee.com

Or follow her on facebook @drkristenyee

* (UCLA Medical Center, ranked #1 in California by *US News & World Report*).

MAD
architecture
(707)765-9222 EXT.1
www.madarc.com
info@madarc.com

(blood sugar)
Pass the test.

The Center for Well-Being is the source for premier diabetes education and support. Arm your patients with the tools they need to manage their Type II Diabetes. Services include:

- Diabetes Meal Planning
- Preventing Diabetes & Heart Disease
- Living Well with Type II Diabetes
- Medical Nutrition Therapy

Classes covered by Medicare and most insurance providers.

CENTER FOR WELL-BEING

707.575.6043 | **NorCalWellBeing.org**
101 Brookwood Ave. • Santa Rosa, CA 95404

Sonoma Medicine

Editorial Board

Jeff Sugarman, MD
Chair
Allan Bernstein, MD
Ana Coutinho, MD
Rachel Friedman, MD
Brien Seeley, MD
Regina Sullivan, MD
Kristen Yee, MD

Staff

Steve Osborn
Editor
Wendy Young
Publisher
Susan Gumucio
Advertising
Linda McLaughlin
Design/Production

Sonoma Medicine (ISSN 1534-5386) is the official quarterly magazine of the Sonoma County Medical Association, 2312 Bethards Dr. #6, Santa Rosa, CA 95405. Periodicals postage paid at Santa Rosa, CA, and additional mailing offices.

POSTMASTER: Send address changes to *Sonoma Medicine*, 2312 Bethards Dr. #6, Santa Rosa, CA 95405.

Opinions expressed by authors are their own, and not necessarily those of *Sonoma Medicine* or the medical association. The magazine reserves the right to edit or withhold advertisements. Publication of an ad does not represent endorsement by the medical association. Email: scma@scma.org.

The subscription rate is $27.80 per year (four quarterly issues). For advertising rates and information, contact Susan Gumucio at 707-525-0102 or susan@scma.org.

www.scma.org

Printed on recycled paper.

© 2017 Sonoma County Medical Association

Letter from the Executive Director

We have been very busy here at SCMA during my brief tenure. We held an **open house** on May 1st at the SCMA office and enticed you with libations and appetizers. We had a lovely turnout that resulted in new board members and new SCMA members! In the medical society world, that is indeed a successful event and well worth the effort. We were all thrilled to meet each of you and look forward to similar events soon.

SCMA joined more than 500 physicians, medical students and stakeholders in Sacramento on April 18th to bring the voice of medicine to legislators for the 43rd annual **CMA Legislative Advocacy Day**. SCMA was represented by Dr. Peter Sybert and Dr. Rob Nied, along with SCMA Executive Assistant Rachel Pandolfi and myself. We spent the day meeting with Assemblymembers Marc Levine and Jim Wood, as well as Sen. Bill Dodd and an aide to Sen. Mike McGuire. Key legislative issues that we discussed included AB 1048 (Arambula) which would reduce pressure on physicians prescribing opioids; SB 641 (Lara) which would clarify privacy related to CURES; Proposition 56 and tobacco tax fund allocations; and graduate medical education.

Our annual **Wine & Cheese event** held on May 24th at the Deerfield Winery in Kenwood was another great success. The location was perfect, the weather cooperated fully, the food was delicious, the wine was outstanding, and the guests were engaging. Photos of the event begin on page 34.

SCMA has applied for **501(c)(3) nonprofit status** as the Medical Society of Sonoma County. With our new status, we will better serve our members and our community. Stay tuned for details!

For the summer, SCMA has partnered with Cold Stone Creamery to bring you a **summer essay contest** (see page 18). The topic is "**Tell us about an 'Aha!' moment.**" The essay contest includes cash prizes and is open to family members of all SCMA physicians. Check the monthly *SCMA News Briefs* for details, or contact me for info.

We understand that free time equals family time, so we are striving to balance professional networking opportunities with family-friendly events.

One of those events is a morning **family hike on Sunday, Aug. 27th,** at Shiloh Regional Park in Santa Rosa, followed by a brunch at the park picnic grounds. There will be two simultaneous hikes: an "easy" hike through shaded trees, over water bridges and river trails to Bullfrog Pond; and a more moderate hike up the hills and through the vineyards to one of the best views in Sonoma County. Both hikes are 2–3 miles long and last 60–90 minutes. Join us for brunch, bocce ball and horseshoes after!

Family Day at Safari West is Nov. 4th, with tours at 10 a.m. and 1 p.m. Lunch sponsorship opportunities are available! This is a great way for sponsors to reinforce the physician wellness message. Say it, mean it, support it! Contact me for details.

Membership is steadily increasing. We have 56 new members since the beginning of 2017. We hope that is a sign of things to come. We are excited about the future of SCMA and look forward to creating new and engaging opportunities for our members. If you have any suggestions, please contact me. My door is always open!

Finally, the new **2017–2018 physician directories** are available at the SCMA office if you still have not picked up your copy. Stop by to pick up a directory and say hello anytime!

P.S. **See page 11 for an important SURVEY about *Sonoma Medicine.* We need your feedback!**

Wendy Young
707-525-4141
exec@scma.org

Dr. Rob Nied (left) meets with Assemblymember Jim Wood on CMA Legislative Advocacy Day.

SCMA staff, medical students and physicians meet with Assemblymember Marc Levine.

SCMA members picking up their physician directories at the Open House in May.

PHOTO BY TIM SARTORIS

Trail in Shiloh Ranch Regional Park, Windsor.

Reduce Office Workload
Expand Patient Service
Retain Pleased Patients

Patients new to Medicare and Medicare Insurance will enjoy thorough presentations of all Medicare Insurance options. Plus, they receive complete enrollment assistance.

FREE Service: **Gary resolves Medicare Patient's insurance claim issues** by working as long & resourcefully as needed with insurance companies, pharmacies & other health care providers.

FREE Service: Because many assisted people will prefer & appoint Gary as their Medicare Insurance broker.

Why Gary Smith:

1977 Graduated from U.C. Berkeley. **1982** Health Insurance licensed in Sonoma County.

1989 to 1993, the Sonoma County Medical Association endorsed Gary, as one of two representatives for its physician's disability insurance program. **SCMA endorsed Gary because of his excellent service to many physicians' patients, employees, families and/or themselves.**

To request Informative Kits, call 707-576-8100

2016 TESTIMONIALS

My girlfriend asked ***"Where did you find that guy?"*** She asked after I told her about Gary making many phone calls to resolve a communications problem between a pharmacy, my physician's office and two departments inside of the insurance company. ***Beverley Saul***

From his presentation of Medicare Advantage, to his assistance in arranging my upcoming surgery & organizing my appeal of Medicare part D penalties, **Gary was understanding, accessible and supportive**. ***Larry Coulter***

Gary provides fast responses with thorough answers. He clearly wants to help and he succeeds. ***Vidya Frazier***

Gary met with me at Social Security's office. **He helped with three Social Security employee meetings**. ***Lawrence Dilley***

In 1983, Gary first worked with my Medicare Insurance brokerage. **In 30+ years, I have found Gary to be a person of his word. Gary is a very fine person, a person of integrity.** ***Greg Macdonald***

Gary Smith, Owner/Broker
Bear Flag Insurance
CA Insurance License # 0631991
799 Piner Road #106,
Santa Rosa, CA 95403

Phone: 707-576-8100
Cell: 707-478-0210 call /text
Fax: 800-454-0369
Gary@SmithBrokerage.com
www.BearFlagIns.com

The Great Single-Payer Debate

Anastasia Coutinho, MD, MHS

I don't want you to worry, but Nik is in the hospital," said my brother's best friend's mother, adding that my brother had passed out while camping, was carried five miles out of the forest by his friends and taken to the closest hospital, where he was determined septic from a ruptured and gangrenous appendix. He was pumped full of fluids and antibiotics prior to surgery and spent a total of four days in the hospital. He returned to back-country camping shortly thereafter, without a worry about access to follow-up care, advice for complications, or co-pays and bills.

My brother lives in Canada—a country that enjoys universal health care coverage through a single-payer system. In Canada, the government replaced private insurance companies, negotiating with and paying doctors and hospitals directly from funding provided by taxes and governmental subsidies. Each citizen and permanent resident has access to a wide range of services, from primary to hospital care, and pays no out-of-pocket costs aside from prescription medications, which are also independently negotiated to be affordable.

Dr. Coutinho, a third-year resident at the Santa Rosa Family Medicine Residency, serves on the SCMA Editorial Board.

Just south of the border, the United States spends more money on health care, both publicly and privately, than any other high-income country, yet has a shorter life expectancy and poorer health outcomes.[1,2] A recent study also shows that we have one of the largest income-based health disparities in the world, with 38% of those in the poorest third of Americans reporting "fair or poor" health, compared with only 12% of the richest third.[3]

Statistics such as these have been driving a movement toward bettering and equalizing health care in the U.S. The Affordable Care Act has led the way by increasing the number of insured patients, increasing access to care, decreasing out-of-pocket costs and improving self-reported health status.[4] Nonetheless, our local, state and federal governments must still confront the inherent inequities of a for-profit health care industry. One possible solution to financial inequities is single payer, a Canadian-style universal health care system, commonly known as Medicare for All.

On June 1, the California State Senate passed SB 562, which seeks to establish a single-payer system for the Golden State; the measure now awaits action in the Assembly. Under SB 562, the state government would negotiate prices with doctors and hospitals, and all Californians would receive complete coverage regardless of immigration status or ability to pay. The bill, however, does not detail how the plan would be funded, a challenge that eventually led to the downfall of a single-payer attempt in Vermont.[5]

An initial Senate estimate detailed the cost of SB 562 at close to $400 billion annually,[6] but a more recent economic analysis from the University of Massachusetts found the cost would be $331 billion and could possibly save the state $37.5 billion annually in health care spending.[7] In either case, some of the money needed to implement SB 562 (at least $200 billion) could be obtained through existing Medicare and Medicaid funds—but the shift would require approval from the federal government.

This issue of *Sonoma Medicine* examines single payer from both sides of the table. Two local family physicians, Dr. Parker Duncan and Dr. Richard Powers, comment on the pros and cons of single payer and how it might affect medical practice. Juan Thomas, an associate director of the California Medical Association, outlines CMA's "oppose unless amended" position on SB 562, and Dr. Toni Ramirez and Dr. Jenny Fish describe the health care advocacy efforts of H-PEACE (Health Professionals for Equality and Community Empowerment).

While these articles offer varying perspectives on single payer, they concur on one key point: Health care is a political issue, and the way to make changes is to get involved in the political process. Your voice counts. ◇

Email: coutinaj@sutterhealth.org

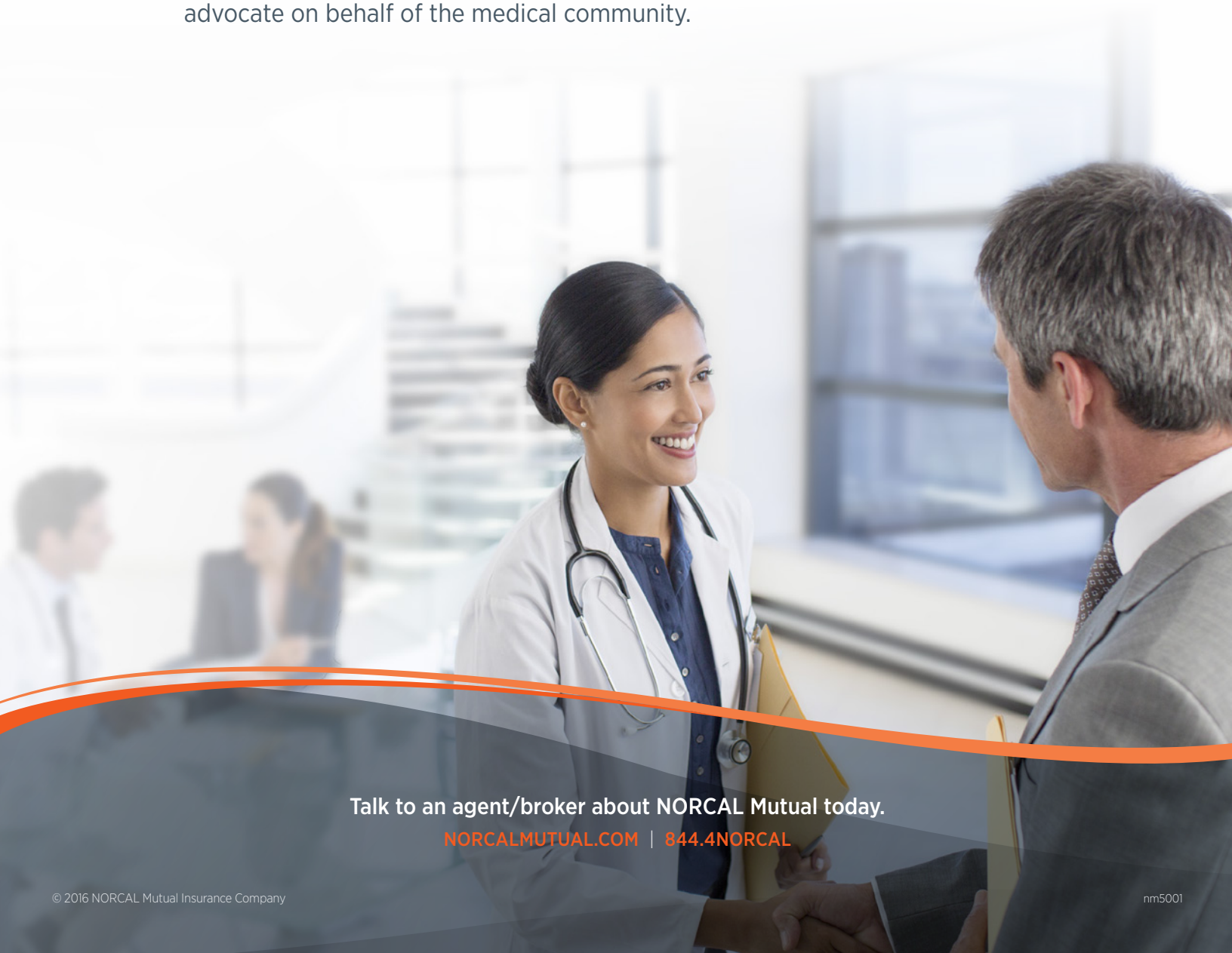
References appear on page 31.

NORCAL MUTUAL®

MEDICAL PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS DESERVE

Offering top-tier educational resources essential to reducing risk, providing versatile coverage solutions to safeguard your practice and serving as a staunch advocate on behalf of the medical community.



Talk to an agent/broker about NORCAL Mutual today.

NORCALMUTUAL.COM | 844.4NORCAL

© 2016 NORCAL Mutual Insurance Company

Envisioning Single Payer

Parker Duncan, MD, MPH

Single payer is a term that seems intuitive at first, yet can quickly become complex and confusing. To better understand what it means, I invite you to envision a theoretical "day in your life" if suddenly we were living and working in a single-payer environment.

Imagine your reception area, where your patients feel welcomed and know that they will not be asked whether they have insurance. Your receptionist does not spend time confirming enrollment or photocopying a new version of an insurance card. Instead, everyone has a card, the same card he or she has had since birth, and will have until death: a card that covers all costs of the visit, without co-pays or deductibles. That's single payer.

Imagine your medical assistant not having to inquire about recent urgent care or hospital visits, and then hunt online or have the patient sign a form to "pull records" from another clinic or hospital. Instead, all parts of a patient's history are accessible on one electronic platform, regardless of which point of care he or she has visited. That's single payer.

Imagine, as well, your patients *choose* to be your patients; that they actually have a choice of whether to come to your office or someone else's, because the "provider network" includes all of us who participate in the single-payer system. Patient choice promotes clinical competency. That is also single payer.

Imagine not having to subvert your clinical thinking with the quandary of which insurance a patient has, which medication might be covered, or how a co-pay might affect the patient's ability to continue your next steps in management, imaging studies or referrals. Instead, you treat based upon your clinical judgment, exercising appropriate clinical autonomy. That is single payer.

Imagine, further, your office is reimbursed for every visit and every service within 30 days, or you are on a globalized budget determined at the beginning of the year. Imagine that you do not need to hire extra staff to process billing and seek reimbursement for medical care you have already administered. Instead, most staff contribute to activities that enhance clinical care and improve office flow. That's administrative efficiency; and that is single payer.

Finally, imagine that you never have to worry whether your own family members have health insurance, regardless of their age, job or health status. Imagine that your family's budget does not include line items for co-pays, deductibles or additional costs from unexpected medical bills. Further, imagine that the term *medical bankruptcy* (a uniquely American phrase) no longer exists in our lexicon; that no individual sits at the dinner table at night consumed by those worries. That is single payer.

A single-payer financing system covers everyone from womb to tomb, with all necessary medical and dental care, for much less than our current model. Single payer incorporates consumer choice and supports the private delivery of health care—be it from solo providers, health centers, laboratories or imaging centers—all of which drives competition toward quality of care. In health care improvement jargon, single payer promotes the "triple aim" of better patient experience, improved health and lower cost.[1]

Single payer offers a massive simplification of the financing side of our health care world, moving from thousands of private health insurance plans to a single public fund. It has been well documented that administrative waste consumes more than 25% of every health care dollar in the current system.[2] This figure encompasses not only every clinic and hospital's cost of figuring out how to bill a different health insurance plan, but also the equally burdensome administrative work inside each insurance company to process and decide whether to pay a claim.

Implementing single payer on a national level could lead to annual cost savings of up to $500 billion (even conservative estimates are $300–400 billion).[3] These savings would come from reduced administrative costs and from lower costs for medications and durable medical equipment—lowered because a single payer has much more bargaining power than an individual insurance company. Eliminating the 25% of administrative waste would then provide more than enough resources to provide comprehensive benefits to everyone.[3]

Health economist Gerald Friedman,

Dr. Duncan is a family physician at the Southwest Community Health Center in Santa Rosa, a board member for the California Physicians' Alliance, and chair of the Single Payer Interest Group of the American Academy of Family Physicians.

who authored the fiscal study[4] for the single-payer bill currently before Congress (HR 676), observed, "Paradoxically, by expanding Medicare to everyone we'd end up saving billions of dollars annually. . . . Such a financing scheme would vastly simplify how the nation pays for care, restore free choice of physician, guarantee all necessary medical care, improve patient health and, because it would be financed by a program of progressive taxation, result in 95% of all U.S. households saving money."[5]

Long considered a fringe fantasy of progressive voters, single payer actually has both liberal and conservative features: it is both wise economics and correct health care.

In single payer, health care *de facto* becomes a human right—everyone is included. While this value is the norm internationally, the United States has, by omission, taken a stance to the contrary; but that is shifting, and rapidly. Progressive voters now strongly support health care for all, and more and more conservatives have begun to understand the economic and human value of universal coverage. Many recent polls have shown the public's acceptance and desire for some form of single payer.[6] Results are similar among physicians, with variance among specialty and region.[7]

Support for single payer comes from the understanding that single payer is not only the smartest way to fund and pay for health care, but is also good for the economy. Uncoupling health insurance from employers benefits both workers and employers. As a position paper from last year's Bernie Sanders campaign noted, "Americans will benefit from the freedom and security that comes with finally separating health insurance from employment. That freedom would not only help the American people live happier, healthier and more fulfilling lives, but it would also promote innovation and entrepreneurship in every sector of the economy. People would be able to start new businesses, stay home with their children or leave jobs they don't like knowing that they would still have health care coverage for themselves and their families."[8]

Prominent business figures have also begun to recognize the potential of single payer. In a possible sign of a pro-business "tipping point," both Warren Buffett and his Republican business partner Charles Munger have advocated for single payer as pro-business, noting that it relieves owners from paying for something unrelated to their business, and therefore promotes business efficiency.[9]

Figure 1. **CMA Single-Payer Resolution** (2007)

Resolved

That CMA reaffirm its existing policy on a single-payer health care system (Resolution 211a-06) as follows:

That CMA considers a single-payer plan to be a recognized form of health care delivery; and

That CMA will continue to consider a single-payer health reform proposal, if the following criteria, at a minimum, are in place:

1. Physicians must be provided a means to ensure payment of their usual and customary charges as defined by the Gould criteria.
2. A scientific, apolitical body must make benefit/coverage decisions.
3. Pluralistic delivery system options must be retained (e.g., pre-paid group practices, FFS).
4. There must be a mechanism for addressing fraud.
5. Patients [must be] allowed to "buy up"—to purchase additional coverage outside the "single" plan.
6. There must be a mechanism to address capital investment and infrastructure building.
7. Medically appropriate co-payments on a sliding scale must be incorporated to discourage excessive utilization.
8. Physicians must be permitted to collectively negotiate.

Medical societies have for years either shunned or ignored proposals to consider single payer, but that is also changing. Last year, the California Medical Association approved a resolution to study single payer and other "alternative financing" models that could benefit health care and support a strong physician workforce; the results of that study are due later this year.

In 2007, CMA approved a "conditional support" resolution for single payer, depending on how eight preconditions are met (Figure 1); but they have taken an "oppose unless amended" position on the single-payer legislation (SB 562) that recently passed the California Senate (see page 15). "Conditional support" and "oppose unless amended" are essentially "show me first" stances rooted in skepticism of state government's ability to handle such a massive undertaking. This attitude is understandable given the current battle to prevent the misallocation of Tobacco Tax funds.

CMA's conditional support of single payer is significant because its lack of opposition to a health-related bill often spells legislative success. If SB 562 continues its steady march through the state legislature, current CMA priorities give the association the flexibility to at least not oppose the bill, and potentially to endorse it. Among other benefits, SB 562 could have a positive effect on the seven "top issues" that CMA identifies on its website: ensuring access to quality medical care; strengthening public health; promoting health education and advancing careers in health; protecting the physician-patient relationship; working to protect patients; preserving economic stability; and advancing new technologies.[10]

In my specialty's academy, the American Academy of Family Physicians, we also are seeing movement toward single payer at both the state and national levels. Several state chapters of the AAFP, including Oregon, New York, Illinois and Minnesota, have already endorsed single payer. Last year, our national Congress of Delegates passed

a resolution to study the likely impact of single payer to family medicine, primary care in general, and population health. Preliminary results of that study will be reported at this year's Congress in September.

I serve as chair of the AAFP national interest group for single payer. We are coordinating efforts to promote education about single payer and its benefits to primary care specialties, including physician satisfaction. We are also conducting an economic analysis that documents the overall efficiencies of care delivery and the promotion of private delivery and patient choice of access.[11]

I also serve as a board member for the California Physicians Alliance, whose mission is to establish a publicly financed, nonprofit health care system in California and the nation. Founded in 1987, the Alliance has always championed health care for all. Over the years, though, our focus has shifted toward single payer as the most equitable and efficient way to finance our health care system. While that remains our ultimate goal, we also support a number of initiatives that would improve care now.[12]

While criticisms and critiques of single payer abound, I have found that many simply amount to fear of the unknown. One example is the issue of physician reimbursement. Single payer can support either a fee-for-service model (likely for small practices) or global budgets for clinics and hospitals, where more and more physicians are salaried. Because a well-functioning health care system relies on a robust primary care structure, single payer should bolster salaries in those specialties, but not at the expense of lower salaries for subspecialists. Because administrative savings from single payer will be directed toward clinical care activities, and because the system prioritizes community health over the profits of health care insurers, it is much more likely that physician pay will be incentivized to produce good outcomes.

As a military veteran (I was stationed on the *USS Nimitz* during the first Gulf War), I have a deep belief in service to country. I became a physician for similar reasons—as a way to contribute positively to our society. Analogous to the Winston Churchill quote about democracy being a bad form of government—except compared to all the other options—single payer is not perfect. Nonetheless, while single payer technically just describes the mechanism to publicly finance the private delivery of health care, it would accomplish more than any other proposal to promote the ideals of our profession, align correct incentives of care and foster business efficiency.

The time has come for single payer. As health professionals, we can have a dramatic impact on the success of its birth and childhood development. The more we as health professionals are involved in that process, the better will be the outcome for our patients, for our profession, and for our society. ◇

Email: pduncs@gmail.com

References

1. Berwick DM, et al, "The Triple Aim: care, health and cost," *Health Aff,* 27:759-769 (2008).
2. Woolhandler S, et al, "Costs of health care administration in the United States and Canada," *N Engl J Med,* 349:768-775 (2003).
3. Woolhandler S, Himmelstein DU, "Single-payer reform," *Ann Intern Med,* 166:587-588 (2017).
4. Friedman G, "Funding HR 676," www.pnhp.org (2013).
5. Almberg M, "Medicare for All would cover everyone, save billions in first year," www.pnhp.org (2013).
6. DiJulio B, et al, "Kaiser Health Tracking Poll: December 2015," kff.org (2015).
7. Sullivan K, "Two-thirds of Americans support Medicare for all," www.pnhp.org (2011).
8. "Medicare for all," position paper, berniesanders.com (2016).
9. Serwer A, "Charlie Munger says single-payer healthcare is the solution," finance.yahoo.com (2017).
10. "CMA's top issues," www.cmanet.org (2017).
11. AAFP, " Single payer health care member interest group," www.aafp.org (2017).
12. caphysiciansalliance.org

SURVEY: SCMA WANTS TO KNOW!
How do you prefer to receive *Sonoma Medicine*?

SCMA uses membership dues to create and publish *Sonoma Medicine.* During this time of transition, the board of directors is considering converting the magazine to an online, electronic publication in lieu of printing and mailing hard copies. This conversion will save member dues, staff time and resources, allowing SCMA to consider new member benefits. *Sonoma Medicine* is a longstanding publication of SCMA, making this a difficult discussion. Please help the SCMA Board of Directors with this discussion by responding to this brief survey. We need your input!

_____ **I want to continue receiving the printed version of *Sonoma Medicine*.**
- _____ SCMA Physician Member
- _____ Nonmember Physician
- _____ Neither, but I enjoy the magazine nonetheless!

_____ **I want to receive *Sonoma Medicine* electronically.**
- _____ SCMA Physician Member
- _____ Nonmember Physician
- _____ Neither, but I enjoy the magazine nonetheless!

_____ **I would prefer not to receive the magazine in any form.**

Please share your response with SCMA by Aug. 31. Survey can be returned via **mail** to SCMA, 2312 Bethards Dr. #6, Santa Rosa, CA 95405, or by:

Fax: 707-525-4328 | **Phone:** 707-525-4375 | **Email:** scma@scma.org

Your opinion is important to this discussion! Please take a moment to share your thoughts.

Do you know What, When and How to Report Child Abuse?

FREE ONLINE CME COURSE!

Course can be offered in a group training using one log-in. Contact Leslie Iacopi at (415) 882-5167 for more details.

· Course developed by the Child Abuse Prevention Center
· Course available 24/7
· Approved for 1.25 AMA PRA Category 1 Credits™
· ALL healthcare providers (MD, DO, RN, PhD, LCSW, MSW) are encouraged to take this valuable course!

Institute *for* Medical Quality

Register NOW at:

http://www.imq.org/education/caprrc.aspx

California Single Payer Pros & Cons

Richard Powers, MD

There are pros and cons to California's single-payer proposal (SB 562), just as there are with any political proposal. The devil is in the details of how the law is implemented.

Pros

The most favorable aspect of single payer is its elimination of the huge percentage of health insurance premiums that the insurance companies take. I truly believe that the insurance companies keep almost 30% of the premium even though the law has restricted them to 15%. They do this by calling their actions "medical care" when they send us a letter telling us that we have prescribed two drugs that might interact or that we committed the sin of prescribing a drug on the Beers Criteria medication list. There are many similar loopholes that allow insurance companies to keep more than their legal 15% of premium. In contrast, Medicare is administered for 6% of the total cost.

The second main benefit of single payer would be reducing the complexity of too many options that confuse patients and physicians and make billing impossible to understand, let alone to protest. The complexity of options leaves physicians guessing if a service is a benefit for a particular patient, meaning that we have to call and wait forever on insurance company phone hold. The complexity also increases the insurance companies' administrative cost. Reducing the need for prior authorizations down to Medicare level would be an incredible savings.

Dr. Powers, a former president of SCMA, is a Sebastopol family physician.

There are other benefits to single payer. Reducing the huge salaries of insurance executives, as well as their administrative bureaucracy, would greatly improve the share of medical spending that could go for care. Shareholder and other profits would be removed from the cost of the medical system, and insurance agents and their commissions could be eliminated and replaced with the equivalent of the Health Insurance Counseling & Advocacy Program (HICAP).

Cons

The most serious threat from single payer is that the government could pay all care at Medi-Cal rates, which are typically one-third to one-fourth of Medicare rates. Medicare includes a 20% senior discount, so the minimum payment for patients not eligible for Medicare should be at least 120% of Medicare.

Physicians traditionally have not been able to organize enough to defend their rights in the political arena, even though CMA has been more effective than AMA. Witness the atrocity of the sustainable growth rate, where AMA could not protect physicians from a law that reduced physician fees by whatever the total Medicare cost inflation was "to keep Medicare sustainable." Physicians will never recover economically from those 12 years of no increase in reimbursement while our overhead rose at the medical inflation rate. Now we are reclassified as "providers," not deserving of professional pay.

Organized groups benefited during those 12 years, and they will be the ones dividing the state's single-payer budget. Hospitals received a 4% increase during each of those years, and nurses' salaries in California rose to near the highest in the nation. Unless physicians become much more politically active, we will probably see a relative decrease in our share of the medical budget. (The reduction of our billing cost would be a perfect excuse for reducing our reimbursement, not to mention our altruistic instinct to see that every Californian has access to medical care.)

The chances of passage of single-payer legislation in California are almost zero because the insurance companies have much deeper pockets even than the tobacco companies. The insurers will be fighting for their survival and their profit, so the sky is the limit to their war chest against single payer. They beat down the "public option" because they knew that it would soon put them out of business. In addition, Gov. Jerry Brown is not in favor of bigger government or more taxes, so he will probably veto the legislation unless it is brought through as a referendum.

Single payer could also burden us with absurd demands for data that would take the joy out of medicine and make us scribes and data-entry clerks.

TRACY ZWEIG ASSOCIATES
INC.
A REGISTRY & PLACEMENT FIRM

Physicians
Nurse Practitioners ~ Physician Assistants

Locum Tenens ~ Permanent Placement

Voice: 800-919-9141 or 805-641-9141
FAX: 805-641-9143

tzweig@tracyzweig.com
www.tracyzweig.com

There might be no option to practice outside the single-payer system. Or could the California system be like Medicare and leave room for "direct patient care"?

Finally, single payer may institute more guidelines with less ability to individualize care. That makes it easier to replace us with clerks and nurse practitioners, thus saving lots of money. Single payer could also restrict formulary or allowed procedures, even though the government could possibly negotiate drug prices.

Summary

I do not think single payer has a chance at this time, but it has many benefits and many hazards. If single payer does come to pass, physicians must become much more organized and politically active than we have ever been. ◇

Email: drpowers@sonic.net

Home Health Care, Inc.
When Experience Matters
707.538.0679
• Assistance with Daily Living
• Home Safety & Companionship
• Dementia & Hospice Care
• Diet & Exercise Programs
• Post-operative Care
• RN Oversight on All Cases
• RN Case Management
• Skilled Nursing Services
• Special Medical Conditions
• Medicine Management
• All Services Available 24x7
• State Licensed & Bonded
• Locally Owned since 1987
BBB ACCREDITED BUSINESS
homehealthcareinc.net
Call 707.538.0679 for your FREE in-home Evaluation

California Medical Association
Physicians dedicated to the health of Californians

April 25, 2017

The Honorable Ed Hernandez
Chair, Senate Health Committee
California State Senate
State Capitol, Room 2080

Re: SB 562 (Lara/Atkins)
CMA Position: Oppose unless Amended

Dear Senator Hernandez:

On behalf of the more than 43,000 members of the California Medical Association, we write to take an Oppose unless amended position on SB 562.

The CMA shares the authors' goal of universal health care coverage for all Californians, but at this time SB 562 is counterproductive to maintaining and expanding the gains in coverage made by the Patient Protection and Affordable Care Act. While California's implementation of the PPACA is not perfect, it has resulted in more than 5 million additional citizens gaining health care coverage. For seven years, providers, policymakers, regulators, health plans, consumer groups and others worked hard to create a health care market place that works for all those who provide and consume health care. The bill would unravel this achievement and place significant uncertainty and risk on our physician members and their patients during what is sure to be a lengthy and complex transition to single-payer, government-run health care agency.

While the CMA considers a single-payer plan to be a recognized form of health care delivery, we oppose SB 562 unless all of the following criteria are contained in the legislation.

1. **Physicians must be provided a means to ensure payment of their usual and customary charges as defined by the Gould criteria.** The bill does not contain a provision that addresses these criteria.

2. **A scientific, apolitical body must make benefit and coverage decisions.** SB 562 would create the Health California Program which is to be governed by a board of nine members, appointed by the Governor, Senate Committee on Rules and the Speaker of the Assembly that shall have demonstrated and acknowledged expertise in health care. However, given the composition of the board, it is debatable whether it is scientific and it is certainly not apolitical.

3. **Pluralistic delivery system options must be retained.** It appears that SB 562 contemplates a capitated system and fee-for-service; this would have to be finalized through regulations adopted by the Healthy California program board.

4. **There must be a mechanism for addressing fraud.** SB 562 addresses program and conflict-of-interest standards; however, there is no specific mechanism for addressing fraud.

5. **Patients allowed to "buy-up" – to purchase additional coverage outside the "single" plan.** The bill appears to allow health care plans and health care insurers, if authorized, to offer benefits to cover health care services that are not offered to individuals under the "single" program.

6. **There must be a mechanism to address capital investment and infrastructure building.** SB 562 does contain a provision for payment of capital-related expenses, however, regulations would need to be adopted on payment methodologies and prior approval for capital payment expenses would need to be obtained, which will impede innovation and not allow health care demands to be met quickly.

7. **Medically appropriate co-payments on a sliding scale must be incorporated to discourage excessive utilization.** There is no provision in the bill that addresses these criteria.

8. **Physicians must be permitted to collectively negotiate**. This is provided for in the bill under sections 100662, 100664 and 100645.

Finally, SB 562 lacks any type of funding mechanism. In 2008, when the Legislature was considering a single-payer system under SB 810 (Leno), the Legislative Analysts' Office (LAO) estimated annual costs of $210 billion in the first year of implementation. The LAO also predicted a net shortfall of $42 billion in the first implementation year and $46 billion in subsequent years. It is certain that this cost will be significantly higher in today's health care environment as a single-payer plan would need to collect enough funding to replace current insurance premiums, all cost sharing and deductibles, enough dollars to pay for Medi-Cal and the cost of additional uninsured enrollees.

The CMA appreciates that the authors attempted to include some of these necessary criteria; however, SB 562 would have to specifically include all of the abovementioned criteria in order to remove our, oppose unless amended position.

For these reasons, CMA respectfully asks for a no vote on SB 562 unless amended. I can be reached at (916) 444-5532.

Sincerely,

Juan Thomas
Associate Director, California Medical Association

cc: The Honorable Ricardo Lara
Members, Senate Health Committee
Scott Bain, Consultant, Senate Health Committee
Joe Parra, Consultant, Senate Republican Caucus

Sutter Medical Group of the Redwoods
AFFILIATED WITH SUTTER PACIFIC MEDICAL FOUNDATION

A physician-owned, multi-specialty practice serving Sonoma County

JOB OPPORTUNITY FOR FAMILY MEDICINE AND INTERNAL MEDICINE PHYSICIANS

• 1–2 years guaranteed income • Relocation allowance • Sign-on bonus
• Generous compensation and benefits

Please send CV to Isabelle von Tobel: vontobi@sutterhealth.org | www.sutterhealth.org
Locums opportunities available

Health Care Activism

Toni Ramirez, MD, Jenny Cecilia Fish, MD

Health Professionals for Equality and Community Empowerment (H-PEACE) is a health care activism group based in Sonoma County. We are health professionals united by a common conviction that health is a human right and that all human beings deserve to be treated with dignity and respect regardless of their country of origin, immigration status, race, religion, gender identity, sexual orientation or any other factor. We are committed to engaging civically; fostering an understanding of the impact of policies on health; addressing racial disparities; denouncing xenophobia, intolerance and hatred; protecting access to health insurance and full-spectrum reproductive health services; and defending environmental and social justice.

Our membership of nearly 200 health care providers includes family physicians, pediatricians, nurse practitioners, midwives, nurses, medical assistants, psychologists, public health workers, students and collaborative social justice groups. Within this membership, we provide services in every health system in the county.

Dr. Ramirez and Dr. Fish are Santa Rosa family physicians.

Our group formed shortly after last November's elections to defend health care rights and institutions from threats that may affect the health of our community. As health care providers, we understand the complexities and fragility of our communities' medical needs and strive to work towards justice as it pertains to all the factors that affect our patients' lives. We believe we have a powerful voice that should be used to advocate for our community.

We have established core values in five areas: health care access and reform, reproductive justice, immigrant rights, LGBTQI rights, and environmental justice. Threats to these areas are intricately linked to the health of our community, and health activism starts from the intersection of them all.

We have accomplished a great deal since last November. We have met with members of Congress on local and national health policy, testified for a sanctuary city and affordable housing, provided resources on health care services offered in the county, facilitated education on immigration within our clinics, lobbied in Sacramento, served as volunteer medics at marches, organized our own demonstrations, and collaborated with local social justice organizations. We are most proud of creating strong relationships with local organizations to make significant change on a local level for years to come.

As health professionals, we see every day how the Affordable Care Act has helped our patients, and we are adamantly opposed to any repeal of the ACA. The potential loss of health coverage for 23 million Americans and the projected $800 billion in cuts to Medicaid are unacceptable. According to local and state officials, repeal of the ACA in Sonoma County may cut benefits and coverage for 150,000 local residents, eliminate 2,000 jobs, and lead to more than $200 million in economic losses.

But let us be clear: even if the ACA does survive, it's not enough. Our patients are still suffering and dying from lack of affordable access to equitable and quality health care. That's why we are supporting SB 562, the Healthy California Act, which would create a single-payer health care system for all of California. We firmly believe that health care is a human right and will fight to help California lead our country towards what every other industrialized nation embraces: universal health care for all.

H-PEACE meets monthly, and location varies. If you are a health professional who wants to join our group or a community organization that wants to collaborate, contact hpeacesantarosa@gmail.com. ◇

THE 2017 SCMA KIDS'

Summer Essay Contest

PRESENTED BY

SONOMA COUNTY MEDICAL ASSOCIATION

IN COLLABORATION WITH

COLD STONE CREAMERY

Have you ever had an "Aha!" or "Eureka!" moment? If you have, and feel inspired to write a compelling personal essay about it, you may be able to win cash prizes in the Sonoma County Medical Association's first-ever **Summer Essay Contest.**

Categories:

Ages 5–7: Submit an essay: Word count defined by you.

All submissions will receive a Cold Stone Creamery Gift Certificate.

Ages 8–12: Submit an essay with 500–700 words.

1st prize: $150
2nd prize: $50

Ages 13–17: Submit an essay with 700–1,000 words.

1st prize: $150
2nd prize: $50

Qualifications: This Summer Essay Contest is open to all SCMA member physicians' families (including children, grandchildren, nieces, nephews, cousins, etc.)!

Submissions: Submit by email to **exec@scma.org** and provide a printed copy in presentation format (photos encouraged!) to the Sonoma County Medical Association, 2312 Bethards Drive, Suite #6, Santa Rosa, CA 95405. Submissions due by Friday, Aug. 11, 2017.

Winners will be published in the fall 2017 issue of *Sonoma Medicine* (the quarterly magazine of SCMA). First-place winners will be invited to the SCMA Awards Gala to be held on Thursday, Dec. 7 at the Vintners Inn in Santa Rosa. All submissions will be posted in *SCMA News Briefs* throughout the summer and fall and online at www.scma.org.

Questions: Contact SCMA at 707-525-4375 or via email at scma@scma.org.

JOIN US!

The Sonoma County Medical Association Alliance Foundation

We are a nonprofit organization made up of physician families committed to creating a healthier Sonoma County by improving the lives of those in need. Our members are empowered to enact change in their own community while building a network of friendships that can last a lifetime. We invite you to become a member. Find us at *www.scmaa.org*.

givelaughworkshareThe SCMAAF

SCMA President Peter Sybert, MD

Interviewed by Wendy Young, SCMA Executive Director

Dr. Sybert in his Santa Rosa office. *Photo by Duncan Garrett.*

Born in Montreal, Canada, in 1953, Peter Sybert grew up all over North America and Europe because his father worked for oil companies and was transferred frequently. The family ended up in Redwood City, where Peter completed high school. He then matriculated to UC Berkeley, graduating with an AB in biochemistry in 1975. Four years later, he received his MD from Columbia University P&S, followed by an internship in internal medicine at Cedars-Sinai Medical Center in Beverly Hills, and a residency and fellowship in anesthesiology at UC San Francisco.

In 1984, Dr. Sybert moved to Sonoma County and began his private practice. He co-founded the Anesthesia & Analgesia Medical Group in 1991 and currently serves as its chief financial officer. He has been active in SCMA and the California Society of Anesthesiologists for many years, serving as president of CSA from 2013 to 2014.

Dr. Sybert is married to Delinda Sybert, and they have two grown daughters: Elysia and Camille. This interview was conducted at Dr. Sybert's office in Santa Rosa on May 18.

What are the greatest challenges facing the medical system in Sonoma County?

Health care is going through a period of disruptive change. The Affordable Care Act is in place, and California has implemented the Covered California insurance exchanges. This has resulted in a marked decrease in the number of uninsured patients, and a marked increase in the number of patients who have health insurance and are accessing the health care system. What's going to happen next is entirely unclear, as we are back into another era of disruptive change. We will have to wait and see what the laws are that our elected officials decide on.

How will the local system be affected if the Affordable Care Act is repealed or replaced?

I was just in Washington, DC, a few days ago talking with our legislators about this. It is impossible at this point to understand what is going to be repealed, and if so, what it is going to be replaced with. However, there are some fundamental principles that I believe need to continue. Patients need access to health care, and they need it in an affordable fashion. We need to preserve the ability for people with pre-existing conditions to access health care in a reasonable fashion, and there needs to be a broad suite of clinical situations that are covered. The provider networks need to be broad enough that patients can access the health care they need.

Local hospitals are full, and they are sending patients elsewhere. Would it be better to keep hospital care in Sonoma County? How could we do that?

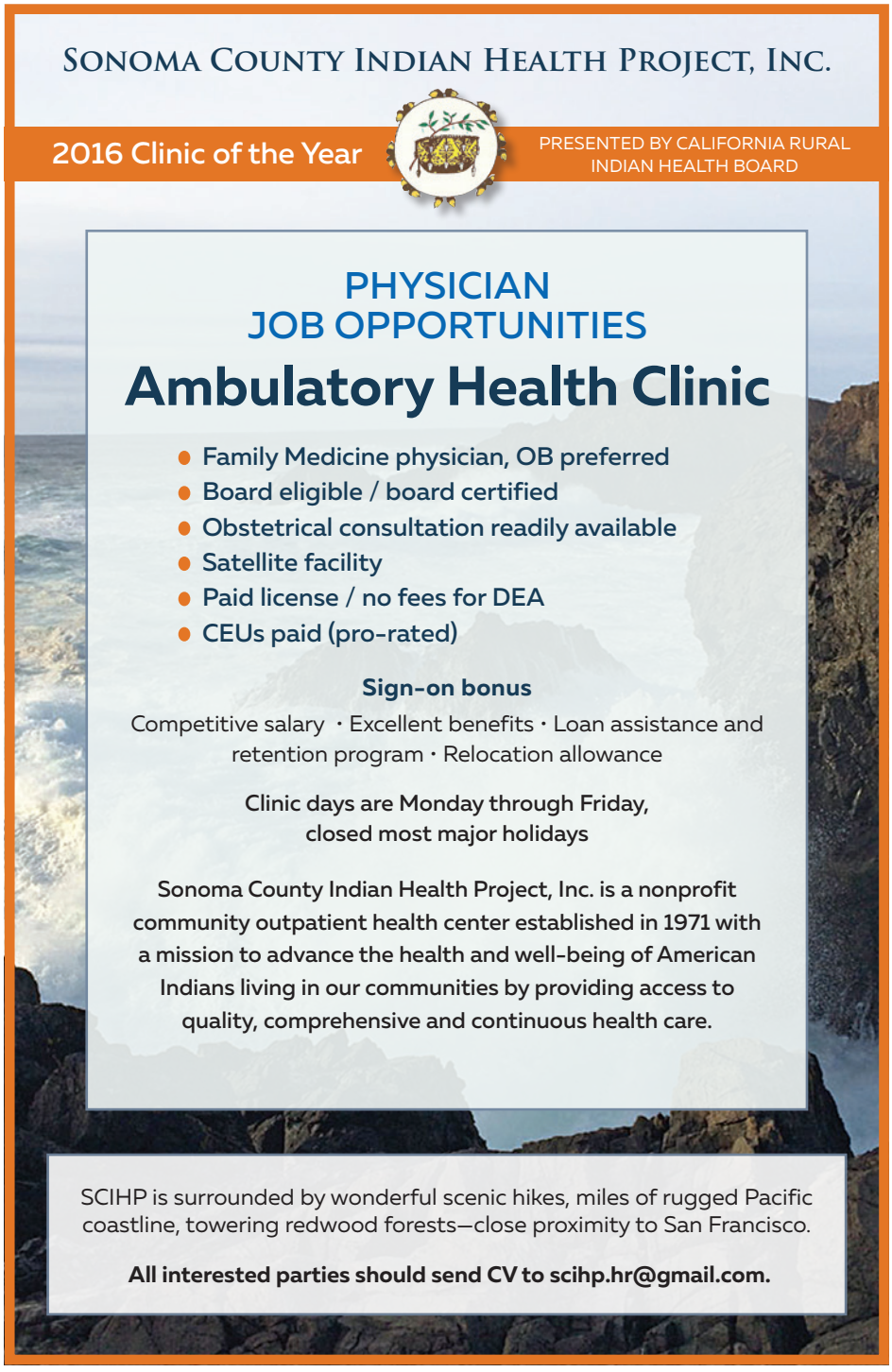
For the clinical situations that can be taken care of in the county, yes, it's better to keep care here. It's better for the patients and their families as they can be together and support each other. It's a more familiar environment to patients, and their primary care physicians can be more involved with their care and treatment.

It's true that there's a limited amount of bed space, but the other dynamic is that more and more patient care is being delivered in an ambulatory setting. Bigger procedures are being done safely in ambulatory surgery centers, and different modalities are being developed to take care of these patients. The

amount of time that patients spend in a facility continues to decline as health care delivery systems become more efficient. Patients can recover from their underlying problems much more rapidly.

What is your view on single payer, and how might it compare to the current system?

Several years ago, the California Medical Association took the position that all alternative modalities for health care delivery should be examined, and single payer is clearly one of those. There is current legislation in Sacramento to enact a single-payer system, but we don't know how that would be implemented and financed. Could a single-payer system work? Sure, but it depends upon the details of the system, and none of that has been defined yet in California.


SONOMA COUNTY INDIAN HEALTH PROJECT, INC.
2016 Clinic of the Year
PRESENTED BY CALIFORNIA RURAL INDIAN HEALTH BOARD
PHYSICIAN JOB OPPORTUNITIES
Ambulatory Health Clinic
Family Medicine physician, OB preferred
Board eligible / board certified
Obstetrical consultation readily available
Satellite facility
Paid license / no fees for DEA
CEUs paid (pro-rated)
Sign-on bonus
Competitive salary • Excellent benefits • Loan assistance and retention program • Relocation allowance
Clinic days are Monday through Friday, closed most major holidays
Sonoma County Indian Health Project, Inc. is a nonprofit community outpatient health center established in 1971 with a mission to advance the health and well-being of American Indians living in our communities by providing access to quality, comprehensive and continuous health care.
SCIHP is surrounded by wonderful scenic hikes, miles of rugged Pacific coastline, towering redwood forests—close proximity to San Francisco.
All interested parties should send CV to scihp.hr@gmail.com.

What is the greatest value in being a member of SCMA?

It's the opportunity to have your voice heard in an era of disruptive change by the people who are decision makers. There are some very tough decisions to be made at the state and national level, and if you aren't participating as a stakeholder, the decisions will be made in your absence. It's important to have a voice at the table. Being a member of and engaged in the SCMA leadership allows me to have a voice at the table and speak on behalf of our members.

Why do you think membership in SCMA is declining?

That's a problem across medical societies. Medical societies can be expensive, especially if you belong to several of them. Demographics can also be an issue. It's clear that some physicians can't be reached with the more traditional approaches. Medical societies need to review current processes and adapt to new communication trends.

Describe one potential change that SCMA can make to reach that next generation of leaders.

I think the newest graduates are more in tune with information electronically. They derive more content and knowledge on their various electronic devices. If you want to be relevant in their world, you have to participate in their world and not expect them to stay with more traditional models. It's just not a part of their lives. We need to go where they are.

Medical societies can deliver value, but if physicians don't appreciate that the value is there, that's the same as not having value, practically speaking. From my perspective, participating in SCMA and CMA delivers value well beyond price. We are the stakeholders who represent the physician community in Sacramento on patient care. Representing yourself in Sacramento at the individual level is great, but the legislators want to know what CMA believes on an issue. Attending on behalf of CMA/SCMA is analogous to more than 600 SCMA physicians walking into their office.

How do you plan to increase SCMA membership during your presidency?
We need to identify how our next generation of physicians can be reached in a way that is relevant to them, so that they see SCMA as not just another expensive dues organization, but an organization that delivers value to them beyond price and delivers information to them in a way that they are eager to receive. It's not whether they can afford to belong, but can they afford to not belong?

Do you have any projects or plans for your presidency?
This is a transition year. We have a new executive director, Wendy Young, and we implemented a new strategic plan last year. We are also starting a nonprofit foundation to look for grants and resources that we can apply toward the strategic plan. It's a wonderful and exciting time. Disruptive change in health care is loaded with challenges, but it's also a wonderful time to be part of the leadership of an organization. With care and thought, we can have an impact on how things evolve.

What are your main interests outside of medicine?
Photography has always been a big part of my life. I started off in high school, where I used to work as a darkroom tech in a portrait studio. Being a photographer was fun when I was in college, because I had a press pass, so I could get down on the sidelines of all the different games and see football from the sidelines, basketball from right up front!

When kind of photos do you take now?
I like the detail of fine structures, such as the shapes of crystals and the internal structures of plants.

Is there an event in your medical career that has been particularly memorable for you?
There was a young woman who had an ectopic pregnancy. When she left the emergency room, she was awake, alert and oriented. I met her on her arrival in the pre-op area, and in the meantime she had ruptured her ectopic pregnancy and was now comatose and unresponsive. That was a time to recognize the situation, the urgency of what was going on. We had to pull together the resources within a couple of minutes that would normally come together within a half hour so we could head to the operating room and get this situation taken care of. She did wonderfully well, and she got her life back. That's part of what makes medicine rewarding. That was a great experience.

Do you have any final thoughts?
I am looking forward to the year that's coming up. It's going to be loaded with challenges. It will have its twists, its turns, its unexpected events—but there's a wonderful team of people on the board of directors, a new executive director and a great team at the SCMA office. It's going to be a fun year. ◇

For 40 years, we've been here for you.

St. Joseph Health℠
Hospice Services

- **Two medical directors** with over 66 combined years of hospice experience.
- **Local nurses** available days, evenings and weekends.
- A robust **Grief Services program** serving hospice families and all members of the community.
- All services in **English and Spanish.**

NORTH SONOMA COUNTY
Memorial Hospice
Santa Rosa 707-568-1094
North County Hospice
Healdsburg 707-431-1135

SOUTH SONOMA COUNTY
Hospice of Petaluma
Petaluma 707-778-6242
Memorial Hospice
Santa Rosa 707-568-1094

SonomaCountyHospice.org
StJoeSonoma.org

OPEN CLINICAL TRIALS
IN SONOMA COUNTY

Beginning with this issue, *Sonoma Medicine* is listing open clinical trials in Sonoma County to increase awareness of local medical research and to benefit physicians who may wish to refer patients. This preliminary list includes six research groups that are conducting open trials. The clinical trials at other research groups are only open to their own patients.

Each listing includes the group's name and address, along with the phone number and email address for the contact person. The trials are listed alphabetically by diagnosis, followed by the experimental treatment(s). The list is subject to change; contact the research groups for the latest information.

Sonoma Medicine has tried to list all current open trials in the county, but we may have missed some. If you know of other open local trials, contact SCMA at scma@scma.org so the trials can be listed in the next issue.

NORTH BAY NEUROSCIENCE

7064 Corline Ct, Suite B-1, Sebastopol
Contact: Susan Smith
707-827-3593, Fax 707-861-9465
susan.smith@northbayneuro.org

Alzheimer's disease

- Crenezumab for prodromal to mild AD.
- Efficacy and safety of CNP520 in participants at risk for the onset of clinical symptoms of AD.
- Effect of LY3202626 on mild Alzheimer's disease.
- Aducanumab in the treatment of mild Alzheimer's disease.

Dementia. Impact of amyloid PET imaging on managing patients meeting appropriate use criteria with early dementia.

NORTH BAY EYE ASSOCIATES

104 Lynch Creek Way #12, Petaluma
Contact: Angela Reynolds
707-769-2240
research@northbayeye.com

Adenoviral conjunctivitis. Povipone-iodine 0.6% and dexamethasone 0.1% ophthalmic suspension for patients with suspect adenoviral conjunctivitis w/watery discharge and infection.

Anterior segment uveitis. Iontophoretic dexamethasone phosphate vs prednisolone acetate for patients diagnosed with non-infectious anterior segment uveitis with anterior chamber cell count ≥11.

Bacterial conjunctivitis

- Vancomycin hydrochloride ophthalmic ointment vs vehicle for suspect bacterial conjunctivitis with discharge and conjunctival injection.
- Povipone-iodine 0.6% and dexamethasone 0.1% ophthalmic suspension for suspect bacterial conjunctivitis with discharge and injection.

Dry eye. KPI-121 0.25% ophthalmic suspension vs vehicle for patients with moderate to severe dry eye disease.

Glaucoma

- Travoprost injection vs timolol for open-angle glaucoma (OAG) or ocular hypertension (OHT).
- Sustained release travoprost punctal plug vs placebo for OAG or OHT.
- Bimatoprost sustained release injection vs timolol for primary OAG or OHT.
- Bimatoprost SR injection vs selective laser trabeculoplasty for primary OAG or OHT.

Presbyopia

- Oxymetazoline hydrochloride vs pilocarpine hydrochloride for healthy patients ages 40-50 with presbyopia.

SUMMIT PAIN ALLIANCE

392 Tesconi Ct., Santa Rosa
Contact: Chamu Vadapalli
707-623-9803, ext 118
chamu.vadapalli@summitpainalliance.com

Back and/or leg pain. Safety and efficacy of spinal cord stimulator with built in auto-feedback to treat patients with chronic pain of the trunk and/or limbs.

Low back and/or leg pain

- Anatomic vs. paresthesia-mapped placement of spinal cord stimulation leads.
- Benefits of different pulse sequence spinal cord stimulation applications for treating patients with refractory back and/or leg pain.

Low back pain. Safety and efficacy of stem cell rexlemestrocel-L alone or combined with hyaluronic acid in subjects with chronic discogenic lumbar back pain (>6 months) associated with moderate degenerative disc disease.

Lower extremity pain. Dorsal root ganglion stimulation for the management of moderate to severe chronic, intractable pain of the lower limbs due to complex regional pain syndrome (CRPS) types I and II.

Refractory pain. Long-term safety of intrathecal drug delivery pump for patients with severe pain from many sources.

Upper back and/or trunk pain. Efficacy of spinal cord stimulator to treat patients with upper back axial and/or radicular thoracic pain.

REDWOOD DERMATOLOGY RESEARCH

2725 Mendocino Ave., Santa Rosa
Contact: Liza Marie, RN
707-755-3946
liza.marie@ncmahealth.com

Acne (pediatric). Aczone gel 7.5% for 9- to 11-year-olds with moderate acne.

Atopic dermatitis (adult) Investigational phosphate cream for 18- to 70-year-olds with mild to moderate atopic dermatitis.

Atopic dermatitis (pediatric). Dupilumab for 12- to 18-year-olds with moderate to severe atopic dermatitis.

Onychomycosis (pediatric). Jublia for 6- to 16-year-olds with toenail fungus.

Psoriasis (adult). Handheld luma light therapy system for adults 18 years and over with mild to severe psoriasis.

Psoriasis (pediatric). Calcipotriol & betamethasone dipropionate foam for 12- to 17-year-olds with scalp and body psoriasis.

Warts (pediatric). Furosemide topical gel for 12- to 17-year-olds with 1-6 warts.

RADIANT RESEARCH

4720 Hoen Ave., Santa Rosa
Contact: Kathryn Brokke
707-542-1469
kathrynbrokke@radiantresearch.com

Acne vulgaris. Olumacostat glasaretil gel in patients aged 9 and above with moderate to severe acne.

Acute myocardial infarction. Efficacy and safety of sacubitril/valsartan (Entresto) compared to ramipril on morbidity and mortality in high-risk patients following an acute MI.

Alopecia. Phase 2A study of setipiprant tablets in androgenetic alopecia in males aged 18-49 with hair loss.

Chronic heart failure. Efficacy and safety of omecamtiv mecarbil on mortality and morbidity in subjects with chronic heart failure with reduced ejection fraction.

Diabetes. Phase 3 Study to investigate efficacy and safety of finerenone on reducing cardiovascular morbidity and mortality in subjects with type 2 diabetes mellitus and clinical diagnosis of diabetic kidney disease in addition to standard of care.

Psoriasis. Secukinumab (300 mg) compared to ustekinumab in subjects with moderate to severe plaque psoriasis.

ST. JOSEPH HERITAGE HEALTH

3555 Round Barn Circle, Santa Rosa
Contact: Kim Young
707-528-1050
kimberly.young@stjoe.org

Bladder cancer

- Chemotherapy versus combination checkpoint inhibitor therapy in metastatic bladder cancer.
- Durvalumab in locally advanced and metastatic bladder cancer.

Breast cancer

- Post-operative adjuvant NeuVax vaccine and Herceptin in patients with high risk HER2+ tumors.
- Post-operative adjuvant NeuVax vaccine and Herceptin in patients with HER2- tumors.
- BriaVax vaccine for patients with metastatic breast cancer.
- Neratinib or lapatinib plus capecitabine in patients with HER2+ metastatic breast cancer.

Chronic lymphocytic leukemia

- Ibrutinib versus acalabrutinib in patients with previously treated, high-risk CLL.

Colon cancer

- Chemotherapy with or without a stem cell inhibitor for patients with metastatic colon cancer.
- Chemotherapy vs. checkpoint inhibitor in patients with MMR-deficient metastatic tumors.

Gastric cancer

- Pembrolizumab and hyaluronidase in patients with metastatic hyaluronan-expressing tumors.

Head and neck cancer

- Chemo/radiation with or without pembrolizumab for locally advanced head and neck cancer.

Lung cancer

- Post-operative adjuvant chemotherapy plus a third generation tyrosine kinase inhibitor.
- Chemotherapy with or without a stem cell inhibitor for patients with metastatic lung cancer.
- Pembrolizumab and hyaluronidase in patients with metastatic tumors expressing hyaluronan.
- MET inhibitor in patients with metastatic lung cancer harboring a MET mutation.
- ErbB3 receptor blockade in patients with heregulin-expressing metastatic lung cancer.
- Maintenance therapy with rovalpituzumab following chemotherapy for small-cell lung cancer.
- Notch receptor inhibitor versus chemotherapy in recurrent small-cell lung cancer.

Multiple myeloma

- Lenolidamide/dexamethasone with or without pembrolizumab in front line therapy of myeloma.
- Pomalidomide/dexamethasone with or without pembrolizumab for relapsed myeloma.

Ovarian cancer

- Niraparib for patients with platinum-sensitive recurrent ovarian cancer.

Pancreatic cancer

- Chemotherapy with or without hyaluronidase in patients with metastatic tumors expressing hyaluronan.

Prostate cancer

- Androgen deprivation with or without enzalutamide in metastatic hormone-sensitive prostate cancer.
- Rucaparib in patients with HRD-positive metastatic castration-resistant prostate cancer.

Solid tumors

- Entrectinib in patients whose tumors harbor a NTRK, ROS1 or ALK gene rearrangement.
- Multikinase inhibitor in patients whose tumors harbor a BRAF or RET mutation/re-arrangement.

MEMBERSHIP HAS ITS BENEFITS!

Free and discounted programs for SCMA/CMA members

BENEFIT	PROVIDER
Auto/Homeowners Insurance *Save up to 8% on insurance services*	**Mercury Insurance Group** 888-637-2431 • www.mercuryinsurance.com/cma
Car Rental *Save up to 25%*	**Avis or Hertz** 800-786-4262 • www.cmanet.org/groupdiscounts
CME Certification Services *Discounted CME certification for members*	**CMA's Institute for Medical Quality** 415-882-5151 / www.imq.org
HIPAA Compliance Toolkit *Various discounts*	**PrivaPlan Associates, Inc.** 877-218-7707 • www.privaplan.com
ICD-10-CM Training *Deeply discounted rates on several ICD-10 solutions, including ICD-10 Code Set Boot Camps*	**AAPC** www.cmanet.org/aapc
Insurance Services *Save up to 25% on workers' comp insurance and receive special pricing and/or enhanced coverage for life, disability, long term care, medical, dental and more*	**Mercer Health & Benefits Insurance Services LLC** 800-842-3761 cmacounty.insurance.service@mercer.com www.CountyCMAMemberInsurance.com
Legal Services *FREE access to CMA On-Call (online health law library), access to CMA legal staff through the legal information line and more*	**CMA's Center for Legal Affairs** 800-786-4262 • legalinfo@cmanet.org www.cmanet.org/legal
Magazine Subscriptions *Save up to 50% on all subscriptions*	**Subscription Services, Inc.** 800-289-6247 • www.cmanet.org/magazines
Medical IDs *Discounts on 24-hour emergency identification and family notification services*	**MedicAlert** 800-253-7880 • www.cmanet.org/medicalert
Medical Waste Management *Save 30% or more on medical waste management and regulatory compliance services and 50% on the Compliance Portal*	**EnviroMerica** 650-655-2045 • www.cmanet.org/enviromerica
Mobile Physician Websites *Save up to $1,000 on unique website packages*	**MAYACO Marketing & Internet** 209-957-8629 • www.cmanet.org/mayaco
Office supplies, facility, technology, furniture, custom printing and more . . . *Save up to 80%*	**Staples Advantage** 800-786-4262 • www.cmanet.org/staples
Physician Laboratory Accreditation *15% off lab accreditation programs and services*	**COLA** 800-786-4262 • www.cmanet.org/cola
Physician Smartphone App *FREE secure messaging application*	**DocbookMD** www.cmanet.org/docbookmd
Reimbursement Assistance *FREE assistance with reimbursement and contracting issues*	**CMA's Center for Economic Services** 800-401-5911 • economicservices@cmanet.org www.cmanet.org/ces
Security Prescription Products *15% off tamper-resistant security subscription pads*	**RxSecurity** 800-667-9723 • www.cmanet.org/rxsecurity
Webinars and Seminars *CMA works with industry experts to offer timely, high-quality education programs, including FREE webinars and deep discounts on live seminars*	**CMA** www.cmanet.org/events

PUBLICATIONS

CMA Publications

www.cmanet.org/news-and-events/publications/

- ***CMA Alert*** **e-newsletter**
- ***CMA Practice Resources***

CMA Resource Library & Store

www.cmanet.org/resource-library/list?category=publications

- Advance Health Care Directive Kit
- California Physician's Legal Handbook
- Closing a Medical Practice
- Do Not Resuscitate Form
- HIPAA Compliance Online Toolkit
- Managed Care Contracting Toolkit
- Model Medical Staff Bylaws
- Patient-Physician Arbitration Agreements
- Physicians Orders for Life Sustaining Treatment Kit

SCMA Publications

www.scma.org

- ***Sonoma Medicine*** (quarterly)
- ***Sonoma County Physician Directory*** (biennial)
- ***SCMA News Briefs*** (monthly)

CONTACT SCMA/CMA: 707-525-4375 • scma@scma.org

June 2017

Clinical Fasting

Toshia Myers, PhD, Alan Goldhamer, DC

Modern humans evolved while surviving prolonged periods without food and have voluntarily fasted for spiritual and therapeutic reasons since ancient times. Water-only fasting (complete abstinence from all foods and beverages except for pure water) is now used therapeutically to initiate physiological responses that may promote self-healing. Animals, including humans, are capable of varying degrees of cellular regeneration,[1,2] which may be supported by fasting as well as a natural diet and adequate rest.[3,4] Several other claims have been made about physiological responses to fasting, including ketogenesis, hormone modulation, reduced oxidative stress and inflammation, and increased stress resistance, lipolysis and autophagy.[5–8]

Water-only fasting results in the cessation of digestion and a gradual transition into a ketogenic state. During the 4–8 hours after caloric ingestion, available glucose, amino acids and fatty acids in the blood stream are depleted. After approximately 12 hours, glycogen reserves in the muscle and liver are also depleted, and there is a switch from glucogenesis to gluconeogenesis and ketogenesis (a metabolic process that converts fatty acids released from adipose tissue into ketone bodies). A ketogenic state is reached after approximately 48 to 72 hours, depending on an individual's glycogen reserves.[5] Ketosis may spare glucose utilization and reduce protein catabolism during prolonged periods without food.[5,6] Importantly, the human brain may be able to use ketone bodies as an alternate energy source.

In a fasted state, increased autophagy (breakdown and recycling of damaged and non-essential tissue) provides a source of amino acids, fatty acids, and minerals,[9] and the energy previously used for digestion may be directed towards cellular regeneration.[6,7] The aforementioned physiological adaptations, such as a decrease in inflammatory cytokine levels, may also be induced. The fasted state continues until nutrient reserves are depleted, at which point the body enters starvation (a state of chronic nutritional deficiency). Although most well-nourished humans can safely fast for up to 30 days or longer, fasts should always be terminated before nutrient reserves are depleted. Refeeding after a fast is a deliberate, gradual process in which caloric beverages and foods are introduced in increasing complexity to restart the digestive process.[5]

The physiological adaptations that occur in the fasted state may produce various health improvements. Clinical evidence in humans suggests that fasting may reduce hypertension, rheumatoid arthritis, cardiovascular disease, metabolic syndrome, osteoarthritis, fibromyalgia, chronic pain, chemotherapy side effects, and quality of life.[10–21] Water-only fasting may normalize hypertension and borderline hypertension in a relatively short time (10–14 days), without serious adverse events.[10,11] Study results suggest that water-only fasting may have helped reduce systolic/diastolic blood pressure by an average of 37/13 mm Hg in patients with grade 1-3 hypertension and by an average of 20/7 mm Hg in patients with borderline hypertension.[10,11] Natriuresis, vasodilation and weight loss are plausible explanations for this effect. However, the exact mechanism(s) by which fasting may reduce blood pressure and lead to other observable health changes is unknown.

Over the past 30 years, clinicians at TrueNorth Health Center (TNHC) in Santa Rosa have supervised more than 15,000 water-only fasting patients with a protocol that ensures patient safety and treatment efficacy. The clinicians routinely observe apparent improvements in obesity, hypertension, psoriasis, eczema, type 2 diabetes, taste sensitivity, systemic lupus erythematosus, metabolic disorder, rheumatoid arthritis, depression, anxiety and various other diseases, including most autoimmune disorders. Patients with multiple morbidities (e.g., obesity, hypertension, type 2 diabetes and hyperlipidemia) often appear to improve in all areas.

A particularly remarkable case of a 42-year-old female patient at TNHC with stage IIIa, low-grade follicular lymphoma was recently reported in *BMJ Case Reports*.[22] After a 21-day water-only fast, her enlarged lymph nodes were no longer palpable, and CT scans confirmed

Dr. Myers is research director at TrueNorth Health Foundation in Santa Rosa. Dr. Goldhamer directs the TrueNorth Health Center, also in Santa Rosa.

IHM INSTITUTE FOR HEALTH MANAGEMENT

A Medical Clinic / David Chappell, M.D., Medical Director

THE SAFE, EFFECTIVE APPROACH TO RAPID AND PERMANENT WEIGHT LOSS

• Medically Supervised • Nutritional Counseling
• Registered Dietician • Long Term Weight Maintenance

715 Southpoint Blvd., Suite C
Petaluma, CA 94954
(707) 778-6019 778-6068 Fax

350 Bon Air Rd., Suite 1
Greenbrae, CA 94904
(415) 925-3628

Audiology Associates

Offers Solutions to Balance and Tinnitus Problems

Balance Care Program Audiology Associates is devoted to restoring and maintaining the function of the auditory and vestibular system in its Balance Care Program, where patients receive care in a program designed with the latest technology and methods for properly evaluating and diagnosing balance conditions.

Tinnitus Care Program People suffering from tinnitus may experience whistling, hissing, buzzing, ringing or pulsing in the ear that persists even in the absence of external sound. Audiology Associates' comprehensive Tinnitus Care Program provides the most advanced diagnostics and treatments available to help patients manage this condition.

AUDIOLOGY ASSOCIATES
hear today, hear tomorrow

Peter J. Marincovich, Ph.D., CCC-A
Director, Audiology Services

Joseph C. Hardeman, Au.D.
Clinical Audiologist

Daniel S. Park, B.S., Au.D., Extern
Clinical Audiology Extern

See our website for more information
audiologyassociates-sr.com

Three Offices
Serving the North Bay

SANTA ROSA
(707) 523-4740

MENDOCINO
(707) 937-4667

MILL VALLEY
(415) 383-6633

MEMBER OF AUDIGY
AUDIGY GROUP

Visit Dr. Marincovich's BLOG
at drpetermarincovich.com

the size reduction. She did not undergo standard cancer treatment, has maintained a healthy lifestyle, and remains symptom-free two years later.

Despite the possible good outcomes, water-only fasting is not a panacea or appropriate for all people. Water-only fasting is also not a cure or treatment in the traditional sense; it is simply intended to promote the body's self-healing mechanisms. In order to maintain the results obtained by water-only fasting, it is necessary to adhere to a health-promoting lifestyle that includes a diet of minimally processed plant foods, adequate sleep and robust physical activity.

Although evidence may support the use of water-only fasting in disease management, resistance to fasting in the allopathic and alternative medical communities remains strong. One reason is that excessive and uncontrolled water consumption can lead to water intoxication and other potentially fatal outcomes. While complications from fasting can and do occur, we are not aware of any clinical studies indicating that controlled water-only fasting under medical supervision is inherently dangerous or more harmful than other medical practices.

To establish evidence-based knowledge about fasting, TNHC has conducted a retrospective study currently under review to assess adverse events during 768 medically supervised, water-only fasting visits lasting from 2–41 days.[23] Like all retrospective studies, ours may be subject to confounding and bias. Nonetheless, our results show that most adverse events experienced during prolonged water-only fasting are mild to moderate in nature and already known to occur during fasting (e.g., nausea, headache, insomnia, presyncope, dyspepsia, fatigue and back pain). There are limitations to the study because it is specific to the TNHC protocol implemented at TNHC, but the data suggest that water-only fasting conducted under medical supervision appears to be relatively safe.

Scientific and public interest is mounting in the possible anti-aging and health effects of various types of fasting, such as caloric restriction and intermittent fasting.[9] Research in these areas continues to shape our understanding of the potential uses of fasting and the mechanisms by which fasting may promote self-healing. Nonetheless, clinical research on water-only fasting is lacking. To rectify this situation, TNHC has established the TrueNorth Health Foundation (TNHF) to conduct and support unbiased, rigorous water-only fasting research with the goal of improving scientific and clinical knowledge. TNHF is particularly interested in collaborative research investigating the efficacy and cost-effectiveness of water-only fasting in comparison to standard treatment protocols for various disease conditions.

An area of general research interest is the effect of water-only fasting on gut microbiota, the metabolome and intestinal permeability. Anecdotal evidence suggests that fasting may improve these components of gut health, which could be one reason why autoimmune conditions seem to respond to fasting; but there is currently no objective data on this topic. Another long-term objective is to determine how periodic water-only fasting affects "health span"—the length of time that a person is healthy. This is an important question given the advantages of maintaining optimal health rather than managing declining health over a lifetime.

Chronic and largely preventable diseases, as well as associated health care costs, have increased substantially in recent years. The ancient practice of fasting may be a potential antidote to the modern practice of overconsumption. ◇

Email: dracg@truenorthhealth.com

References

1. Carlson BM, "Some principles of regeneration in mammalian systems," *Anat Rec B New Anat,* 287:4-13 (2005).
2. Poss KD, "Advances in understanding tissue regenerative capacity and mechanisms in animals," *Nat Rev Genet,* 11:710-722 (2010).
3. Sharma S, Kavuru M, "Sleep and metabolism," *Int J Endocrinol,* 2010:270832 (2010).
4. Cheng CW, et al, "Fasting-mimicking diet promotes Ngn3-driven beta-cell regeneration to reverse diabetes," *Cell,* 168:775-788 (2017).
5. Fredericks R, *Fasting: An Exceptional Human Experience,* All Things Published Well (2013).
6. Goldhamer AC, et al, *Fasting,* 4th edn, Elsevier Churchill Livingstone (2013).
7. Furhman J, *Fasting and eating for health,* St. Martin's Griffin (1995).
8. Longo VD, Mattson MP, "Fasting: molecular mechanisms and clinical applications," *Cell Metab,* 19:181-192 (2014).
9. Kaur J, Debnath J, "Autophagy at the crossroads of catabolism and anabolism," *Nat Rev Mol Cell Biol,* 16:461-472 (2015).
10. Goldhamer AC, et al, "Medically supervised water-only fasting in the treatment of hypertension," *J Manipulative Physiol Ther,* 24:335-339 (2001).

Compassionate Care | Innovative Treatments | Cutting Edge Research

Accepting new patients and offering a comprehensive strategy to treat pain and restore function, with innovative wellness and regenerative medicine therapies, ultra-minimally invasive regional options and wellness options.

With an individualized, evidence-based approach, and with an unparalleled commitment to success and excellence, we offer regionally, nationally and internationally recognized treatments, including participation in innovative clinical research.

Our affiliation with Sonoma Valley Hospital allows you to receive the quality, multidisciplinary care you deserve close to home.

Summit Pain Alliance

For an appointment

call (707) 623-9803

or visit our website

summitpainalliance.com

GAIL ALTSCHULER, MD
MEDICAL DIRECTOR

CASSALE SHERRIFF
NUTRITIONIST

MARIN WEIGHT LOSS & WELLNESS

MEDICALLY SUPERVISED WEIGHT LOSS PROGRAMS,
LED BY DR. GAIL ALTSCHULER

We welcome Cassale Sherriff, Nutritionist, as we expand our options for personalized and whole food plans for weight loss and optimal health.

Visit our new website and sign up to receive our weekly health & nutrition emails:

WWW.MARINWEIGHTLOSS.COM

415-897-9800 | info@marinweightloss.com

SUITE 411, 400 PROFESSIONAL CENTER DRIVE • NOVATO, CA 94947
SUITE 1, 350 BON AIR ROAD • GREENBRAE, CA 94904

Learn to *live* again

SONOMA RECOVERY SERVICES

OLYMPIA HOUSE

Residential and Intensive Outpatient Treatment

Our philosophy is based upon the recovery model of treatment for chemical dependency that involves the active participation of the individual in developing a person-centered recovery plan that encompasses the whole person and integrates the latest in evidence-based treatment.

Residential Treatment
Detox
Individual Counseling
Group Therapies
Peer Support Groups
Family Therapy
Equine Therapy

Intensive Outpatient Program
Outpatient Individual Psychotherapy
Outpatient Therapy Groups
Aftercare
Case Management Services
Vocational Program

We accept physician referrals.
Please contact us if you have any questions about our treatment program.

OlympiaHouseRehab.com • 888-795-1965
11207 Valley Ford Rd, Petaluma, CA 94952

11. Goldhamer AC, et al, "Medically supervised water-only fasting in the treatment of borderline hypertension," *J Altern Complement Med*, 8:643-650 (2002).
12. Kjeldsen-Kragh J, et al, "Controlled trial of fasting and one-year vegetarian diet in rheumatoid arthritis," *Lancet*, 338:899-902 (1991).
13. Horne BD, et al, "Usefulness of routine periodic fasting to lower risk of coronary artery disease in patients undergoing coronary angiography," *Am J Cardiol*, 102:814-819 (2008).
14. Horne BD, et al, "Randomized cross-over trial of short-term water-only fasting," *Nutr Metab Cardiovasc Dis*, 23:1050-57 (2013).
15. Li C, et al, "Metabolic and psychological response to 7-day fasting in obese patients with and without metabolic syndrome," *Forsch Komplementmed*, 20:413-420 (2013).
16. Steiniger J, et al, "Effects of fasting and endurance training on energy metabolism and physical fitness in obese patients," *Forsch Komplementmed*, 16:383-390 (2009).
17. Schmidt S, et al, "Uncontrolled clinical study of the efficacy of ambulant fasting in patients with osteoarthritis," *Forsch Komplementmed*, 17:87-94 (2010).
18. Michalsen A, et al, "Inpatient treatment of fibromyalgia," *Evid-Based Complement Alternat Med*, 2013:908610 (2013).
19. Michalsen A, et al, "Prolonged fasting in patients with chronic pain syndromes leads to late mood-enhancement not related to weight loss and fasting-induced leptin depletion," *Nutr Neurosci*, 9:195-200 (2006).
20. Dorff TB, et al, "Safety and feasibility of fasting in combination with platinum-based chemotherapy," *BMC Cancer*, 16:360 (2016).
21. Michalsen A, et al, "Incorporation of fasting therapy in an integrative medicine ward," *J Altern Complement Med*, 11:601-607 (2005).
22. Goldhamer AC, et al, "Water-only fasting and an exclusively plant foods diet in the management of stage IIIa, low-grade follicular lymphoma," *BMJ Case Rep*, 2015:211582 (2015).
23. Finnell JS, et al, "Is fasting safe? A chart review of adverse events during medically-supervised, water-only fasting," unpublished data (2017).

MYSTERY CASE

Nocturnal Leg Cramps

Kenneth Herrmann, MD

It's the middle of the night. I'm comfortably asleep in my cozy bed. As I roll over to find another comfortable position, a single leg muscle slowly begins contracting and relentlessly progresses to a full-power contraction. The contraction becomes painful, and I'm unable to make my leg relax. The pain increases. Now I'm no longer comfortable or asleep. This has happened before. A leg cramp! A Charley horse!

I jump out of bed and put the full weight of my body against the pull of the muscle. Slowly the muscle yields and relaxes. I slide back into bed and pull up the covers. As I curl up in my comfortable position, the same painful cramp returns, and I hop out of bed to repeat the stretching and overcome the cramp. Now I'm fully awake.

I slide back into bed again, but I'm afraid to curl up. I lie stretched out, resisting the impulse to bend my leg in the direction of the cramping muscle. Seriously, this is no small matter. I might try to stay awake, but I'm tired. I curl, the muscle cramps again, and I hop out of bed to stretch. As long as I'm awake, I might as well visit the toilet and wee. Back in bed, I resume the stretched posture and try to avoid curling up. I read until I finally curl up and go back to sleep.

These cramps began as rare events and were easily overcome. Eventually they occurred nearly every night and sometimes seemed impossible to overcome. They occur in different parts of my body, but they are always located someplace below my hip. When in my thigh, the cramp usually involves an adductor muscle, maybe the gracilis? When in my leg, it usually involves my ankle, maybe the fibularis longus? A cramp rarely involves my calf muscle, but when it does, I think it probably affects the soleus.

I once studied anatomy and still consult the anatomy books. Shouldn't it be simple to figure out the difference between gastrocnemius and soleus pain? Honestly, in the crisis of cramping I can only identify the area of pain and then stretch the painful muscle. Naming the muscle eludes me. Sometimes the cramp is in the bottom of my foot. I have no idea which intrinsic muscles are involved. I start stretching as soon as a cramp starts. It might be on the left side, could be on the right. Mercifully, cramp attacks rarely involve more than one muscle at a time. I must do an interesting dance on the rare occasion when two muscles cramp at once.

Sometimes I lie down after dinner and watch television. A cramp strikes when I'm drowsy, right when I rise to turn off the television and head to bed. That cramp happens so often at that moment that, fearing the cramp, I am afraid to get up.

I recently started riding with the local bike club. The rides are typically 20–40 miles long. Most of the club members have much more riding experience than the 6,000 miles I have pedaled during the past three years. Fortunately, I don't cramp while riding. One of the more experienced club members suggested that pickle juice might help my nocturnal cramps. I bought a jar of pickles in desperation and took a long drink. The juice didn't reduce my cramps, but it did produce remarkable ankle edema for a few days.

I'm a scientist and a trained physician, so I think, "Physician, heal thyself." I look for a solution. Stretched out in bed in the middle of the night while trying to avoid the next leg cramp is a great time to search the internet. Medical review articles I find tell me that nocturnal leg cramps (NLC) are common, they are associated with various types of muscle stresses, they commonly involve calf muscles, they are painful but self-limited, they may lead to insomnia, and they have no good cure. One clinical trial concluded that stretching before bed might help reduce NLC. I find no other clinical trials registered for NLC. Prophylactic stretching before bed does not reduce my NLC. Then I noticed something others had not mentioned.

What additional observation suggests a non-pharmacologic strategy to relieve my NLC symptoms?

What's the observation? Turn to page 33 for the answer. ◇

Dr. Herrmann is a retired neonatologist in Newburgh, Indiana.

The Torture of Uncertainty

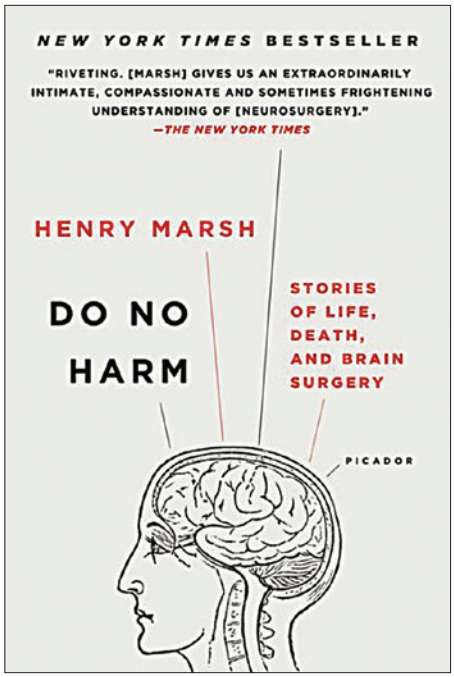
Kristen Yee, MD

Do No Harm: Stories of Life, Death, and Brain Surgery, Henry Marsh, 288 pages, Thomas Dunne Books (2015).

This book was handed to me by my college mentor, a professor of sociology. In spite of my years of training in general, plastic and craniofacial surgery, she knew I retained my love for books and still enjoyed reading others' reflections on surgery and medicine. I recall reading Richard Selzer's *Letters to a Young Doctor* in college, and later feeling that the story "Imelda," about a plastic surgeon Selzer accompanies on a cleft-lip repair mission, nudged me toward my current career.

Dr. Henry Marsh is a neurosurgeon in the Atkinson Morley Wing at St. George's Hospital in London. *Do No Harm* is his first book, although he has been the subject of two major documentary films, *Your Life in Their Hands* (2004) and *The English Surgeon* (2007). The book is a collection of essays, organized superficially by disease type, that contain ruminations on surgery and life arising from Marsh's contact with a particular patient with the diagnosis.

Marsh's writing is as lucid and evocative as Selzer's, although it has a brutal honesty and self-effacement that could be attributed to his Englishness. On the anatomy of the brain while hunting a tumor, Marsh writes:


NEW YORK TIMES BESTSELLER
"RIVETING. [MARSH] GIVES US AN EXTRAORDINARILY INTIMATE, COMPASSIONATE AND SOMETIMES FRIGHTENING UNDERSTANDING OF [NEUROSURGERY]."
—THE NEW YORK TIMES
HENRY MARSH
DO NO HARM
STORIES OF LIFE, DEATH, AND BRAIN SURGERY
PICADOR

> There is a fine, surgical poetry to these names which, combined with the beautiful optics of a modern, counterbalanced microscope, makes this one of the most wonderful of neurosurgical operations—if all goes well, that is. On this occasion as I approached the tumour there were several blood vessels in the way that had to be cut—you need to know which can be sacrificed and which cannot. It was as though I had lost all my knowledge and experience. Every time I divided a blood vessel I shook a little with fright, but as a surgeon you learn at an early stage of your career to accept intense anxiety as a normal part of the day's work and to carry on despite it.

Though neurosurgery is a refined subspecialty of medicine, I think any physician, and surgeons in particular, can identify with Marsh's self-reflections. As might be expected from the title, he discusses cases where the outcome was less than ideal. He considers his own mood and fallibility, the relationship between maturity and aggressiveness as a surgeon, and the truth of making mistakes. In one case, which strikes me as impossible in America, he actually tells a family to sue him after a missed complication leads to devastating results; he is well-aware that his mistake in judgment is indefensible. "I was busy and distracted and I'd never had a serious complication with that particular operation before in twenty years. . . . [At the meeting with solicitors] I felt as though I was attending my own funeral." He finds out later that the health system settled the case for $6 million.

Through these cases and diagnoses, Marsh discusses the changes in medicine wrought by "progress," including the delays caused by switching to an electronic medical record and the change in cerebral aneurysm treatment from surgery to interventional radiology. He leavens the contemporary reflections with anecdotes about his work as a consulting neurosurgeon in the newly independent Ukraine (the subject of *The English Surgeon*), as well as the somewhat different process for medical and surgical training in the UK.

Marsh's criticisms of bureaucracy will be familiar to most physicians, as well as the difficulties of delivering

Dr. Yee, a plastic and craniofacial surgeon in Santa Rosa, serves on the SCMA Editorial Board.

bad or uncertain news when asked to prognosticate. He writes:

> Just as it is irresistible to save a life, it is also very difficult to tell somebody that I cannot save them, especially if the patient is a sick child with desperate parents. The problem is made all the greater if I am not entirely certain. Few people outside medicine realize that what tortures doctors most is uncertainty, rather than the fact they often deal with people who are suffering or who are about to die. . . . It is when I do not know for certain whether I can help or not, or should help or not, that things become so difficult.

One can compare *Do No Harm* to Atul Gawande's *Complications,* at least based on the title, but I prefer Marsh's more personal perspective to some of the policy prescriptions that inevitably emerge from Gawande; Marsh also has the benefit of being a more experienced surgeon. The theme of progress, as well as the universal concerns of uncertainty, sickness, and death, keep this collection of essays relevant despite their sobriety. Marsh's honesty and his often lyrical writing makes *Do No Harm* well worth a read. ◇

Email: ksy@drkristenyee.com

References from page 5

1. Dieleman JL, et al, "Evolution and patterns of global health financing," *Lancet,* 389:1981-2004 (2017).
2. Bradley EH, Taylor LA, *The American Health Care Paradox,* Public Affairs (2013).
3. Hero JO, et al, "U.S. leads other nations in differences by income in perceptions of health and health care," *Health Affairs,* 36:1032-40 (2017).
4. Sommers BD, et al, "Three-year impacts of the Affordable Care Act," *Health Affairs,* 36:1119-28 (2017).
5. McDonough JE, "Demise of Vermont's single-payer plan," *N Engl J Med,* 372:1584-85 (2015).
6. California Senate Appropriations Committee, "SB 562 fiscal summary," assets.documentcloud.org/documents/3728610/SB-0562.pdf (2017).
7. Pollin R, et al, "Economic analysis of the Healthy California single-payer health care proposal," Univ Mass Amherst, www.peri.umass.edu (2017).

LETTER TO THE EDITOR

Dear Editor:

"Single payer. I'm for it."

By this simple declaration, I probably can no longer run for public office without being targeted for defeat by the overpowering lobby of the private insurance industry. If I were a real threat, I might even expect to be scandalized by some unearthed details of youthful indiscretions from my Berkeley days, or worse. (I once flipped off Robert S. McNamara.)

My friends, even the ones who might pardon any youthful indiscretions, advise me: "Get real, Rick. Politics is the art of the possible. Thought you were more mature, more politically sophisticated than this." In a nation buckling under the cost of a health care system that is no system at all, how did such a fiscal no-brainer become such a political non-starter?

Historians have observed that in most wars the first casualty is the truth. In modern parlance, this has come to be known as the "fog of war." The battle over health care in our country has come to resemble a kind of social warfare, dividing us at every level of organized society, from our values and politics to one-sixth of our domestic economy. One bioethicist has called health reform our largest societal challenge since the abolition of slavery.

Legitimate differences of belief and their expression in this debate are already confusing enough. But it doesn't help that most Americans have no way of understanding the Byzantine complexity of how our health services are provided and paid for. This "fog of health care" is no accident. It is a deliberate strategy of the profiteers who benefit most from our arcane system, and who would lose the most if we were to adopt a more rational, more just and more fiscally sound system of health care.

Consider these few undisputed facts:

- Our system remains broken, and it is breaking us; the cost of health care is the largest driver of our national debt, and the most common cause of personal bankruptcy.
- We currently spend more on health care per person (twice as much) than any other nation in the world.
- We achieve mediocre results (37th among all other nations).
- The private insurance industry (1,300 companies, 27,000 plans, 41,000 separate formularies) costs each physician in the U.S. $84,000 annually just to administer billing and reimbursement.
- The pharmaceutical industry now charges $300–$600 for a $6 medication that is lifesaving in children with anaphylactic allergic conditions.
- Ninety percent of the people living in Great Britain have never paid a penny for an insurance premium, co-pay or deductible and enjoy health outcomes far better than ours.
- The average "insured" retiree in the U.S. will pay $250,000 in out-of-pocket health care costs after the age of 65.
- Most of us, including the "insured," live only one medical diagnosis away from bankruptcy.
- We already pay more for health care ($3.4 trillion annually) than it would cost to extend Medicare to all under a single-payer system.
- Under single payer, 96% of Americans, despite increased taxes, would pay less than they are currently paying in out-of-pocket costs for health care. This conclusion is affirmed over decades by multiple analysts, including the Congressional Budget Office and the Government Accountability Office.

Remember these facts in the weeks and months to come when the "fog of health care" descends from the medical industrial complex upon the upcoming single-payer debate. The debate should not be about protecting the existing financing system, but rather what its replacement should be: a failed market-based system that leaves health care unaffordable for tens of millions of Americans, or an affordable, public single-payer system (improved Medicare for all) that takes care of everyone?

Remember also that "Get real" is the same thing King George told a group of colonial complainers who said it was unjust to tax the unrepresented. It is the same thing William Lloyd Garrison was told when he advocated for the abolition of slavery. The same thing the suffragettes were told when they claimed women were smart enough to vote. The same thing a bus driver told Rosa Parks when she sat in the front row of a Birmingham bus.

Single payer isn't perfect. But compared to the disgraceful system we currently endure and pay for? It's time we all get real. ◇

—Rick Flinders, MD

THE WEB'S 10 BEST: TAKE 1

BRIEN A. SEELEY, MD

This is the first installment of a recurring feature where *Sonoma Medicine* shares 10-best lists of web content as compiled by one of its physicians. The lists can include web lectures, performances, movie clips, manuscripts, slide decks or anything else that provides a kind of curriculum of material that the physician finds important and useful for knowing what's out there.

Sites chosen as 10-best should be credible and respectable, do no harm and conform to mainstream journalistic standards of tone, truth and taste. They can include more than just sites with peer-reviewed, prospective, double-blinded studies; they should also include the disseminated, operational views and opinions that drive our patients' and the public's thoughts and actions.

Some of the lectures and narrations selected here have been chosen for their extraordinary import rather than for the brilliance of their presenter, a concession to purpose. I look forward to visiting the 10-best sites that others will offer in future issues of *Sonoma Medicine.*

1. James Hansen, PhD, "Global climate change: how young people can take charge of their future," lecture at Williams College (YouTube video, 72 min, 2017).

A thoughtful, honest, frank presentation by the former NASA astrophysicist and dean of climate science, in which he recounts where we are and where we need to go in protecting our planet. Dr. Hansen offers great clarity, perspective and depth on this topic, along with a plan for realistic studied solutions.

2. Steven Chu, PhD, "Energy and climate change: challenges and opportunities," lecture at University College London (YouTube video, 80 min, 2014).

This authoritative and comprehensive lecture by the Nobel Prize winner and former U.S. Secretary of Energy covers the many aspects of climate change and concludes with a wonderful message about our shared responsibilities.

3. Andy Middleton, "Biomimicry for better design" (TED talk, 15 min, 2014).

Middleton presents marvelous and sustainable designs in nature as guides for how humans could and should design sustainably. He conveys the urgency needed to make this fundamental change—to behave as though we're a part of nature, rather than apart from nature.

4. Alex Steffen, "YIMBY keynote," YIMBY (Yes in My Back Yard) conference (YouTube video, 58 min, 2016).

Steffen, the founder of worldchanging.com, speaks about the increasing economic and environmental challenges that face megacities in their future urban and transportation planning.

5. Jeff Iliff, PhD, "How does our brain get rid of toxins?" (TED talk, 11 min, 2014).

Iliff was part of the University of Rochester team that discovered a brain cleansing system that only functions during sleep. He presents the breakthrough discovery of how sleep refreshes and clears the mind as the brain uses cerebrospinal fluid to cleanse itself of waste and toxins during sleep.

6. Mary Lou Jepsen, PhD, "The science of visible thought and our translucent selves" (TED talk, 18 min, 2016).

Jepsen's brilliant insight is the dissection of neural activity as an image-definable expression. This promises to help us "read minds" and could lead to a new imaging breakthrough, a wearable consumer MRI.

7. Amy Cuddy, PhD, "Your body language shapes who you are" (TED talk, 21 min, 2012).

Cuddy, an associate professor at Harvard University, offers useful and powerful insights into the dynamic interaction of mind and body.

8. Hans Rosling, "Global development" (TED talk, 20 min, 2006).

A beautifully presented statistical analysis of global trends in health, wealth and productivity that concludes with a compelling argument for keeping the web as free as possible to engender learning and analysis.

9. James Taylor, three performances on YouTube:

- **"BBC concert"** (31 min, 1970)
- **"Line 'em Up"** (5 min, 2007)
- **"America the Beautiful"** (2 min, 2013)

Taylor's artistry and personal transformation can be traced with these three performances. His voice, sensitivity and cultural messages have remained true to his times. His inspired rendition of "America the Beautiful" at President Obama's second inaugural is a moving and beautiful bonding experience.

10. Billy Crystal, "The Princess Bride" (YouTube video, 5 min, 1987).

Crystal as the medieval physician Miracle Max in this classic spoof fairy tale is simply hilarious. His bedside manner, along with that of his harridan wife (Carol Kane), shows how *not* to behave with patients and their loved ones. ◇

Email: brienseeley@gmail.com

MYSTERY CASE SOLUTION

Nocturnal leg cramps are defined as cramps in the lower extremities that accompany sleep. Also called night leg cramps, sleep leg cramps, and sleep-related leg cramps, NLCs are a parasomnia: a sleep disorder with associated movements. The diagnosis describes the symptom, so the diagnosis is not mysterious. The mystery lies in the cause and treatment of NLC.

A 2012 review describes NLC as "painful and incapacitating, lasting an average of nine minutes per episode. The acute episode may be followed by hours of recurrent episodes and residual pain. Leg cramps are usually nocturnal and are associated with secondary insomnia." [1] The review identifies no known cause or accepted therapy for NLC.

Stretching prior to sleep has been suggested to reduce NLC, but its effectiveness is debated,[2,3] and it did not work for me. Pharmacologic options for NLC have been suggested,[4] but I am not willing to risk the possible side effects. Home remedies like drinking pickle juice and placing bars of Ivory soap between the sheets didn't work for me, either.

The lack of useful information allowed me to use personal observations to create a method for reducing NLC, test the method, and then modify the method based on my experiences.

Muscles contract in proportion to nerve stimulation that recruits muscle fibers and increases muscle force. Maximal stimulation causes cramps, and athletes exerting maximal effort occasionally cramp. Fortunately, cramping during exercise is not my problem. Cramping during sleep, however, seems distantly related to maximal athletic effort. My NLC episodes increase with periods of endurance cycling and decrease with sustained breaks from endurance training. Canadian prescriptions for quinine, a treatment for NLC, increase in the summer and decline in winter.[5] Increased physical activity of Canadians in summer could explain the seasonal variation of quinine prescriptions for NLC. Increased leg muscle activity probably contributes to my NLC; but avoiding exercise is not a healthy choice, is not my personal goal and does not lead to an acceptable solution for cramps.

I noticed that I needed to empty my bladder after episodes of NLC. A cramp too strong to overcome by stretching would abruptly end after I emptied my bladder. Mild morning cramps also resolved after bladder voiding. These observations suggest that bladder control may contribute to NLC. The bladder's possible influence on NLC suggested a method to reduce cramping and secondary insomnia: use an alarm clock to wake and empty the bladder prior to the onset of a cramp.

I first tried setting the alarm for two hours after bedtime, but painful cramps began just before the alarm sounded. After many modifications, I now set two alarms: the first for 1.75 hours after bedtime and the second for 3.5 hours after bedtime. For example, if I go to sleep at 9 p.m., the first alarm is set for 10:45 and the second for 12:30. Painful episodes of NLC occurred if I used longer intervals or missed waking with either alarm. Cramping rarely occurs after the second alarm, so I don't bother with a third alarm.

Rising from my sleep with an alarm timed to precede a cramp led to additional observations that support the relationship of bladder control with NLC. Waking to wee was more difficult than normal, and voiding felt unusually resisted, as if my bladder sphincter was in spasm. A friend suggested a leg cramp remedy used in pregnancy, which is to stand barefoot on a cold tile floor.[6] I tried applying the technique to my bladder sphincter by moving my feet from the bathroom rug to the cold tile floor during a night void. The cold tile on my feet relieved the feeling of resistance to urine flow, but the cold also made returning to sleep difficult, so I stayed on the rug. Bright lights also hinder returning to sleep, so I use only dim nightlights to guide my path to and from the toilet.[7]

By waking with an alarm clock, emptying my bladder, avoiding cold floors, and eschewing bright lights, I have been able to reduce my painful NLC and secondary insomnia. An estimated 10% of the adult population seeks medical attention for NLC, but the medical community has no cure—yet.[1] The alarm-clock method reduces my NLC and insomnia despite continued endurance training (n=1). I wonder if others with NLC would consider trying this method?

The author welcomes feedback and discussion. Write to NLC.Help.2017@gmail.com. ◇

References

1. Allen RE, Kirby KA, "Nocturnal leg cramps," *Am Fam Phys,* 86:350-355 (2012).
2. Hallegraeff JM, et al, "Stretching before sleep reduces the frequency and severity of nocturnal leg cramps in older adults," *J Physiother,* 58:17-22 (2012).
3. Garrison SR, "Prophylactic stretching is unlikely to prevent nocturnal leg cramps," *J Physiother,* 60:174 (2014).
4. Winkelman JW, "Nocturnal leg cramps," www.uptodate.com (2017).
5. Garrison SR, et al, "Seasonal effects on the occurrence of nocturnal leg cramps," *CMAJ,* 187:248-253 (2015).
6. Riley L, *Pregnancy,* Meredith Books (2006).
7. Haiken M, "Is there a solution for insomnia caused by waking up to use the bathroom?" www.caring.com (2016).

2017 wine & cheese reception

THE 17TH ANNUAL SCMA Wine & Cheese Reception was held in the wine caves at the Deerfield Ranch Winery in Kenwood on May 24, hosted by Robert and PJ Rex. Several dozen physicians, spouses and guests attended the event, which included the ceremonial passing of the gavel and brief remarks by the outgoing president, Dr. Regina Sullivan, and the incoming president, Dr. Peter Sybert.

Event hosts, PJ and Robert Rex, with Obi Wine Kenobi

Dr. Regina Sullivan, her husband, Tim, and their daughter, Tara

Above left, Dr. Ty Affleck and his wife, Dione; *right,* Dr. Jodee Brandon and Trevor Nagle; *left*, Dr. Enrique González-Mendez and his wife, Dr. Mary Maddux-González

Steve Osborn and his wife, Renata Breth

Wendy Young and her fiancé, Jeff Davies

Dr. Jeff Sugarman and his wife, Lisa

Dr. David Lightfoot and his wife, Marsha

Dr. Jackie Senter and her husband, John Gnam

Above, left to right: Dr. Richard Powers and his wife, Charlene; Dr. Brad Drexler and his wife, Pamela; Dr. Tricia May and her husband, Jeff; Dr. Cindy Scharfen and her husband, Jeff

Above center, SCMA guests enjoy the Deerfield Ranch Winery tasting room.

Dr. Peter Sybert presents Dr. Regina Sullivan with a plaque honoring her presidency; Dr. Sybert receives the SCMA gavel from Dr. Sullivan.

A good time was had by all.

— Photos by Will Bucquoy —

2017 ANNUAL SCMA AWARDS

Call for Nominations

Good leaders can influence and motivate others. They have the confidence to stand alone, the courage to make tough decisions, and the compassion to listen to the needs of others. Do you know individual colleagues who demonstrate excellence and a strong commitment to improving our communities?

The Sonoma County Medical Association Awards Committee is seeking nominations for the 2017 awards, which honor individuals who have demonstrated exemplary service. The awards reflect a significant tribute of respect, recognition and appreciation from SCMA member physicians. Awards are also given to nonphysicians and practice managers who have made significant contributions to the advancement of medical science, medical education or medical care. The awards are as follows:

#1 Outstanding Contribution to the Community

Presented to an SCMA member whose work has benefited the community.

#2. Outstanding Contribution to Local Medicine

Presented to an SCMA member who has improved local medical care.

#3. Outstanding Contribution to SCMA

Presented to an SCMA member who has served the medical association beyond the call of duty.

#4. Recognition of Achievement

Presented to a nonphysician who has helped advance local medicine.

#5. Practice Manager of the Year

Presented to a practice manager of an SCMA physician member who has exhibited exemplary service to the practice through outstanding leadership, business planning and development, financial management, implementation of systems and/or knowledge of relevant legislation.

Past recipients are listed on the following page. Physician candidates must be SCMA members and may be nominated for more than one award. If you are unsure if the physician you are nominating is a member, please submit your nomination and SCMA staff will confirm. Self-nominations are encouraged and accepted! You do not have to be an SCMA member to nominate a colleague for an award. Nominations are due by **Friday, Aug. 18**. For more information, contact Wendy Young at 707-525-4375 or at exec@scma.org.

SCMA 2017 Annual Awards Nomination

To: Len Klay, MD, 2017 Awards Committee Chair

From: _____ **Phone** _____
(Name required)

Nominee: _____ **Award:** _____

For more than one nomination, submit separate forms for each. Please provide supporting information, including accomplishments and contributions, that will help the Awards Committee evaluate your nominee. Nominations must received at SCMA **by 5 p.m. on Friday, Aug. 18.** Submit via any of the following methods:

Email to **scma@scma.org** | **Fax** to **707-525-4328**
Mail to **SCMA, 2312 Bethards Dr. #6, Santa Rosa, CA 95405**

THREE DECADES OF AWARDS RECIPIENTS

	Outstanding Contribution to the Community	Outstanding Contribution to Sonoma County Medicine	Outstanding Contribution to SCMA	Special Award for Recognition of Achievement
1985	R. Lee Zieber, MD	James Gude, MD	John Kenney, MD	
1987	Frank Norman, MD		Joseph Schaefer, MD	
1988	Horace Sharrocks, MD		Robert Butler, MD	
1989	Carroll Andrews, MD John Roberts, MD	Richard Barnett MD	Carl Anderson, MD	
1990	Marshall Kubota, MD	Louis Menachof, MD	Ransom Turner, MD	
1991	William Ellison, MD	Harry Ackley, MD	James Clegg, MD	
1992	Harding Clegg, MD Tetsuro Fujii, MD	John Reed, MD	L. Reed Walker Jr., MD	
1993	Thomas Honrath, MD	Lucius Button, MD		
1994	John Sweeney, MD	William Dunn, MD	Thomas Maloney, MD	Helen Rudee
1995	Kenneth Howe, MD	Maurice Carlin, MD Winston Ekren, MD	Leonard Klay, MD	
1996	Gary Johanson, MD Harry Richardson, MD	Michael Gospe, MD	Jerome Morgan, MD	Brother Toby
1997	Salute to Community Service	Salute to Community Service	Salute to Community Service	
1998	Gregory Rosa, MD	James McFadden, MD	Donald Van Giesen, MD	Daryl Schloss
1999	Chris Kosakowski, MD Brian Schmidt, MD	Mark DeMeo, MD	Clinton Lane, MD	
2000	Katherine Walker, MD	Frank Miraglia, MD	Cynthia Bailey, MD	Steve Osborn /Joan Chilton
2001	Jeffrey Miller, MD	Robert Huntington, MD	William Meseroll, MD	Andrea Learned /Larry McLaughlin
2002	Bob Schultz, MD	Louis Menachof, MD	Paul Marguglio, MD	Cynthia Melody/Harry Polley/ Assemblywoman Patricia Wiggins
2003	Amy Shaw, MD	Brien Seeley, MD	Ron Van Roy, MD	Elizabeth Chicoine/Cheryl Negrin-Rappaport
2004	Michael Martin, MD	Jan Sonander, MD	Dan Lightfoot, MD	Sharon Keating
2005	Richard Powers, MD	Mary Maddux-González, MD		Medicare Campaign Leaders
2006	Rick Flinders, MD	Leigh Hall, MD	Lynn Mortensen, MD	Robert Pelligrini
2007	Jose Morales, MD	James Gude, MD	Phyllis "Jackie" Senter, MD	Kay Reed & David Anderson, MD
2009	Walt Mills, MD	Jeff Sugarman, MD	Brad Drexler, MD	Santa Rosa Family Medicine Residency Consortium
2010	Stacey Kerr, MD	Lyman "Bo" Greaves, MD	Richard Andolsen, MD	
2011	Allan Bernstein, MD	Enrique González-Méndez, MD	Kirk Pappas, MD	Operation Access
2012	Jeff Haney, MD	Mark Netherda, MD	Catherine Gutfreund, MD	Redwood Community Health Coalition
2013	Robert B. Mims, MD	Peter Brett, MD	Walt Mills, MD	Northern California Center for Well-Being
2014	Joe Clendenin, MD	Laurel Warner, MD Charles Elboim, MD		Ritch Addison, PhD
2015	Richard Powers, MD	Congressman Mike Thompson, Brad Drexler, MD/Len Klay, MD/ Jan Sonander, MD	Medical Review Advisory Committee	SCMA Alliance Foundation Holiday Greeting Card
2016	Gary Barth, MD	Jerry Minkoff, MD	Rob Nied, MD	Partnership Health Plan of California

Save the Date! *Join us* for the annual

SCMA **Awards Gala**

at Vintners Inn

Thursday, Dec. 7, 2017

Watch for details in the monthly *News Briefs* and in the fall issue of *Sonoma Medicine.*

NORCAL MUTUAL®

Sutter Medical Group of the Redwoods

SPONSORS

PHYSICIANS' BULLETIN BOARD

FOR SALE OR RENT

Exam room to rent
In primary care/sports medicine clinic. Beautiful facilities & reception area. Plenty of parking, close to freeways. Daily, weekly, monthly available. Santa Rosa Sports Medicine, Inc. 1255 N.Dutton Ave, Santa Rosa, CA Dione@srsportsmed.com.

EMPLOYMENT OPPORTUNITIES

PA for Santa Rosa ortho surgeon
Single orthopaedic surgeon looking for physician assistant. Busy practice, no ER call or hospital rounding. PA is responsible for surgery assisting and patient care. Experienced and new grads with ortho rotations preferred. Please send CV with cover letter to Denise at shoulderdoc@ericschmidtmd.com.

Medical back office part-time position
Well-established osteopathic physician in Sebastopol has an opening for a person with office experience. Working knowledge of medical billing through Epic and familiarity with QuickBooks preferred. Additional administrative duties. Please apply with resume. Fax to 707-824-9235.

ON THE MOVE

UROLOGY SERVICES
Now available in Sebastopol
Oreoluwa Ogunyemi, MD,
Stanford-trained urologist
Treating kidney stones, recurrent UTI's, incontinence & overactive bladder, erectile dysfunction, prostate problems.
707-823-7628
Most insurance accepted.

Dr. Stanley Jacobs is proud to announce the addition of **Dr. Eric Culbertson** to his cosmetic surgery practices in Healdsburg and San Francisco. Dr. Culbertson completed his plastic surgery residency at UCLA and general surgery at the University of Michigan. He finished his fellowship in body and breast aesthetic surgery at the University of Texas Southwestern Medical Center in June 2017. He is married and has two young boys.

We welcome Dr. Culbertson to our practice to perform breast and body aesthetic surgery as well as general plastic and reconstructive surgery, such as trauma, flaps, and breast reconstruction.

Sutter Medical Group of the Redwoods would like to welcome their new colleagues for 2017!
Jonathan Albeg, MD, Internal Medicine
Lindsay Aronson, FNP, Oncology
Alexandra Blaufarb, NP, Family Medicine
Rod Camp, MD, Gastroenterology
Emily Conway, MD, Cardiology
John Garcia, MD, Family Medicine
Michael Magnotti, MD, Endocrinology
Aidan Nguyen, DPM, Podiatry
Brian Prystowsky, MD, Pediatrics
Jill Ringer, Pa-C, Urology
Tam Tiet, MD, Family Medicine

SMGR has achieved Elite status for the **CAPG Standards of Excellence Survey** 2017.

Joe Tito, MD, general surgeon, will be opening his practice Sept. 1 at Healdsburg Professional Group (1312 Prentice Dr.) and providing surgical services at Healdsburg General Hospital.

Tom Kaiser, MD, cardiologist (non-invasive), will be opening his practice in mid-July at Healdsburg Professional Group (1312 Prentice Dr.) offering a full range of cardiovascular diagnosis and treatment services.

To post an item on the Bulletin Board, contact Rachel at **707-525-4375** *or* **rachel@scma.org.**

SUPPORT *Our Advertisers . . .*

Audiology Associates	26
Bear Flag Insurance	6
Home Health Care	14
Hospice Services of St. Joseph Health	21
Institute for Health Management	26
Institute for Medical Quality	12
Kristen Yee, MD	3
MAD architecture	4
Marin Weight Loss & Wellness	28
NORCAL Mutual Insurance Company	8
Olympia House	28
Sonoma County Indian Health Project	20
St. Joseph Health	Inside back cover
Summit Pain Alliance	27
Sutter Health	Back cover
Sutter Medical Group of the Redwoods	16
The Doctors Company	Inside front cover
Tracy Zweig Associates	14

THEY SUPPORT THE MAGAZINE!

Value of Membership

◆ PRACTICE ◆ PROFESSIONAL ◆ PERSONAL

SCMA CMA

Here's why **physicians practicing in Sonoma County** should be SCMA/CMA **members:**

- **By speaking as a united voice,** physicians exert a powerful influence on the political process at the local, state and national levels. Organized medicine is the "one voice" that legislators and government hear.
- **SCMA leadership and networking opportunities.** Get to know your Sonoma County colleagues and add your voice to the conversation on local, state and national issues affecting the profession by joining today!
- **Stay up to date on health care issues** affecting Sonoma County physicians with online and print media including *Sonoma Medicine* magazine and *News Briefs* e-newsletter.

• JOIN SCMA/CMA NOW • 707-525-4375 • cmanet.org/membership

The Red Shoes

Matt Joseph, MD

Veteran's Trail, Annadel State Park

It was one of those endless hikes
with my children—minutes filled with galaxies,
hours spilled over with the universe.
We were talking about the thousand years of light
washing over us from dead stars,
life on Mars and whale sharks,
when I saw the scarlet pumps
resting on a bench
where the trail plunged
into the grey-shingled sea
we called our neighborhood—
their pointed toes facing west,
fallen from a fairytale,
no owner to be seen.

Had she wandered, free at last
from trying to impress?
Was she no longer the mistress,
now running barefoot, even as the sun
ran its gaze across the patent leather?
Was she laughing, despite the stones
cutting her pedicured flesh,
or because of them, the pain better
than what came before, real as blood and dirt?
In the end, those high heels
were too small by half, to bear the crush
of my mad romantic notions—
they belonged to someone.
They had been left behind. That was all.

High-pitched voices cracked
my paper-mache reverie,
and names and faces spilled out
as I walked to my waiting children
in my own dusty shoes, their laces
thin as the tether of a kite
at the sky's farthest edge.
There were times I wondered what it might be like
to untie and slip them off
my callused feet, to leave them
on that bench for a day, a week,
for something else,
in those moments of remembering
my life before this one,
the freedom of loneliness,
forgetting my sad stumbling, mapless,
through bare woods at night,
the canopy of dying stars
carving their initials in the snow
with the bones of winter branches.

But they were mine
to slide into each morning,
right and left, choice and covenant,
every day a chance to chase
my son and daughter down the hill
into the grace of tomorrow,
a chance to feel, if granted,
the frost of decades creep
into my knees, my hands, my breath,
to someday meet the children
of my children's children,
to hear the slap of all their feet
against this earth,
rhythmic as the pulse
of a newly hatched star.

Dr. Joseph is a Santa Rosa family physician.

Au Revoir

Steve Osborn

In 1992, after nearly two decades as a freelance writer of elementary and high school textbooks, I got a job with the communications department at Redwood Health Services in Santa Rosa. My main duty was to edit what was then called *Sonoma County Physician*. At my first meeting with the magazine's editorial board, my new boss introduced me to a roomful of skeptical physicians by revealing that I was fluent in French, as if that qualified me to edit medical prose.

I didn't get the bilingual connection until I sat down to edit the first batch of articles, which were written in a foreign language that might as well have been French. A crash course in medical terminology soon followed, but the best translation aid was a thorough review of an old journalism textbook, with its mantra of clarity, brevity and the facts. For brevity's sake, I replaced 50-cent words with shiny dimes and bright pennies, and I transformed an unending parade of verbal nouns back into verbs. For clarity, I untangled vast skeins of tortured sentences and paragraphs, freeing hidden subjects and predicates. The result: articles that entered my in-box at an average length of 2,000 words exited at an average of 1,000.

I trembled when I returned the first batch of edited articles for author approval, but they all called back and uttered some variant of "Is that what I wrote? Looks good to me."

Mr. Osborn is editor emeritus of Sonoma Medicine.

Brevity and clarity were relatively easy to impose, but the facts proved more elusive. How is an English major supposed to determine if a clinical article is sticking to the facts? Reference materials can only go so far.

The solution was all around me. At that time, Sonoma County was home to a thousand physicians, and they were more than happy to read their colleagues' articles in confidence, identify the factual errors and offer feedback. To avoid the inevitable "He said, she said," I used at least two peer reviewers for each article, sometimes three or more. The process was time-consuming and contentious, but the result was always worth the effort.

A thousand physicians is not that many, but they proved more than enough to supply the magazine, eventually renamed *Sonoma Medicine*, with a steady stream of content, split more or less equally between the clinical, the political and the personal. Using a different thematic focus for each issue helped ensure variety, but certain topics, particularly health care reform, came back repeatedly.

Way back in 1992, we published an article trumpeting the California Medical Association's employer-based Affordable Basic Care (ABC) plan, which was "estimated to cost $100 per employee per month, with $75 paid by the employer and $25 paid by the employee." In this issue, we consider a single-payer plan that is projected to cost California $400 billion per year. The numbers have changed, but they're still numbers, and people are still trying to make them work.

The magazine wasn't able to solve the riddle of health care reform over the past 25 years, but it did offer a forum for local physicians to propose solutions and share experiences. In an increasingly divisive medical landscape, our doors were always open for anyone who wanted to set pen to paper.

Those doors continue to be open, but the welcoming committee is about to change. After a quarter century of editing *Sonoma Medicine*, I have decided to retire. There's no reason other than the passage of time and the lure of a deadline-free existence.

Before I leave, I'd like to thank everyone who has made my work such an unbounded pleasure and a stimulating challenge. I am first of all grateful to the dozens of physicians who have served on our editorial board, some for many years. They have worked diligently to review article submissions, develop themes and guide the magazine. I am grateful as well to the SCMA leadership and board of directors for supporting *Sonoma Medicine*, and to my colleagues who not only design, proof and lay out the magazine, but also sell the advertising needed to keep it going.

Most of all, I am grateful to the hundreds of authors and reviewers who have filled these pages over the past 25 years with clinical articles, political tracts, personal essays, book reviews, editorials, mystery cases, travelogues, reminiscences, speculations, musings, stories, journal entries, photographs, paintings and poetry. Without them we would be nothing. ◇

St. Joseph Health

REGIONAL TRANSFER CENTER

Do you need to refer a patient for specialty or tertiary services? Call on St. Joseph Health Regional Transfer Center.

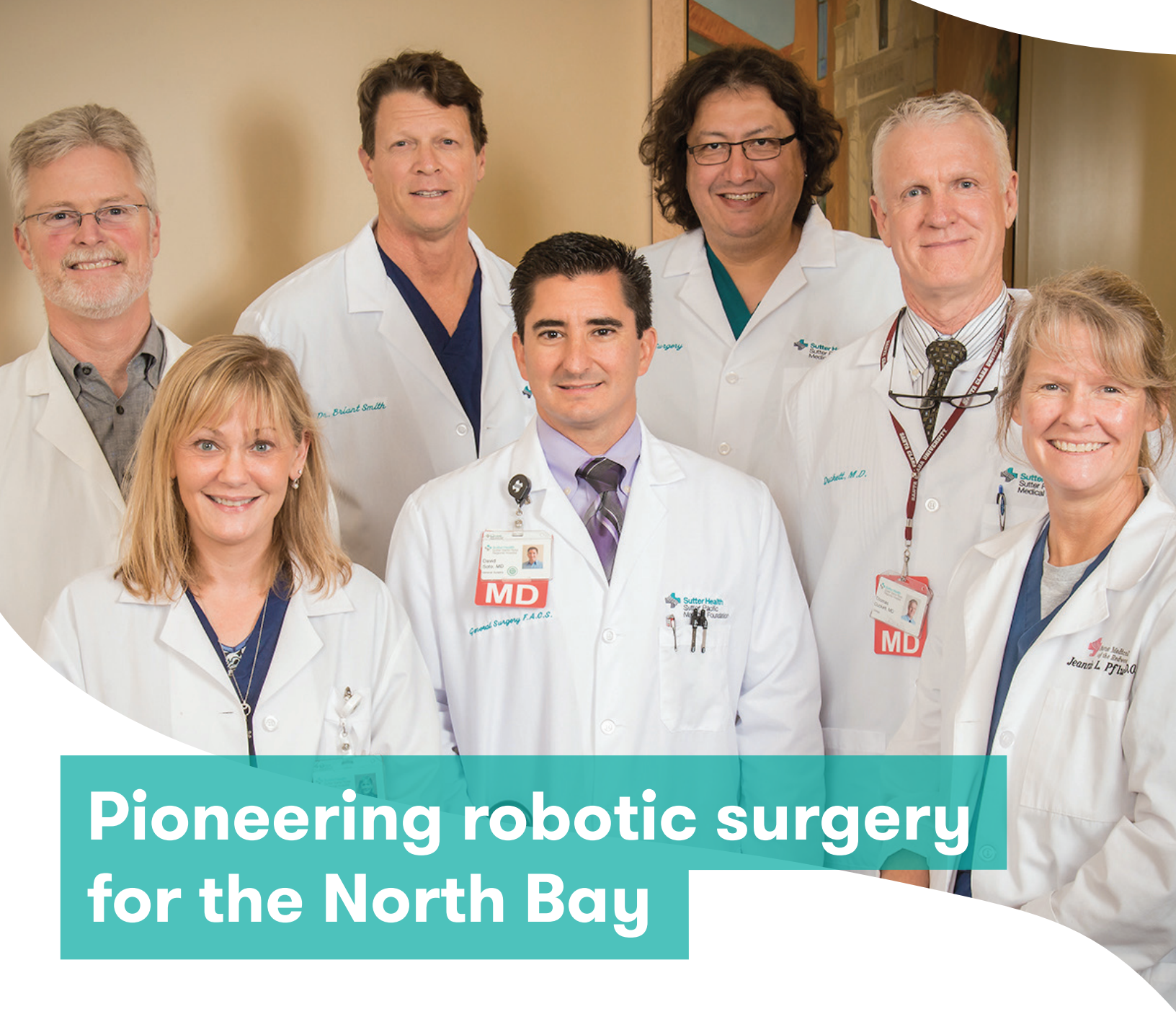
Your one-stop Regional Transfer Center makes referrals for a wide array of diagnoses easier than ever before. One call puts you in touch with all you need to find a specialist and arrange for transport quickly and easily.

To transfer a patient to a St. Joseph-affiliated hospital in Northern California, please call

(855) 4STJOES
(855) 478-5637

St. Joseph Health℠

Queen of the Valley • Redwood Memorial
St. Joseph • Santa Rosa Memorial • Petaluma Valley



Pioneering robotic surgery for the North Bay

If you're looking for advanced-care specialists, consider surgeons at Sutter Pacific Medical Center. Board-certified specialists use the region's only robotic-assisted technologies, such as the da Vinci Xi® and MAKO® surgical systems, which promote optimal recovery. These types of minimally invasive surgeries often result in fewer complications, smaller scars and less pain.

When your patients need the very latest in surgical care, call our referral line at **888-834-1788.** We're pioneering specialty care for the North Bay.

Sutter Health
Sutter Pacific
Medical Foundation

sutterpacific.org/surgery